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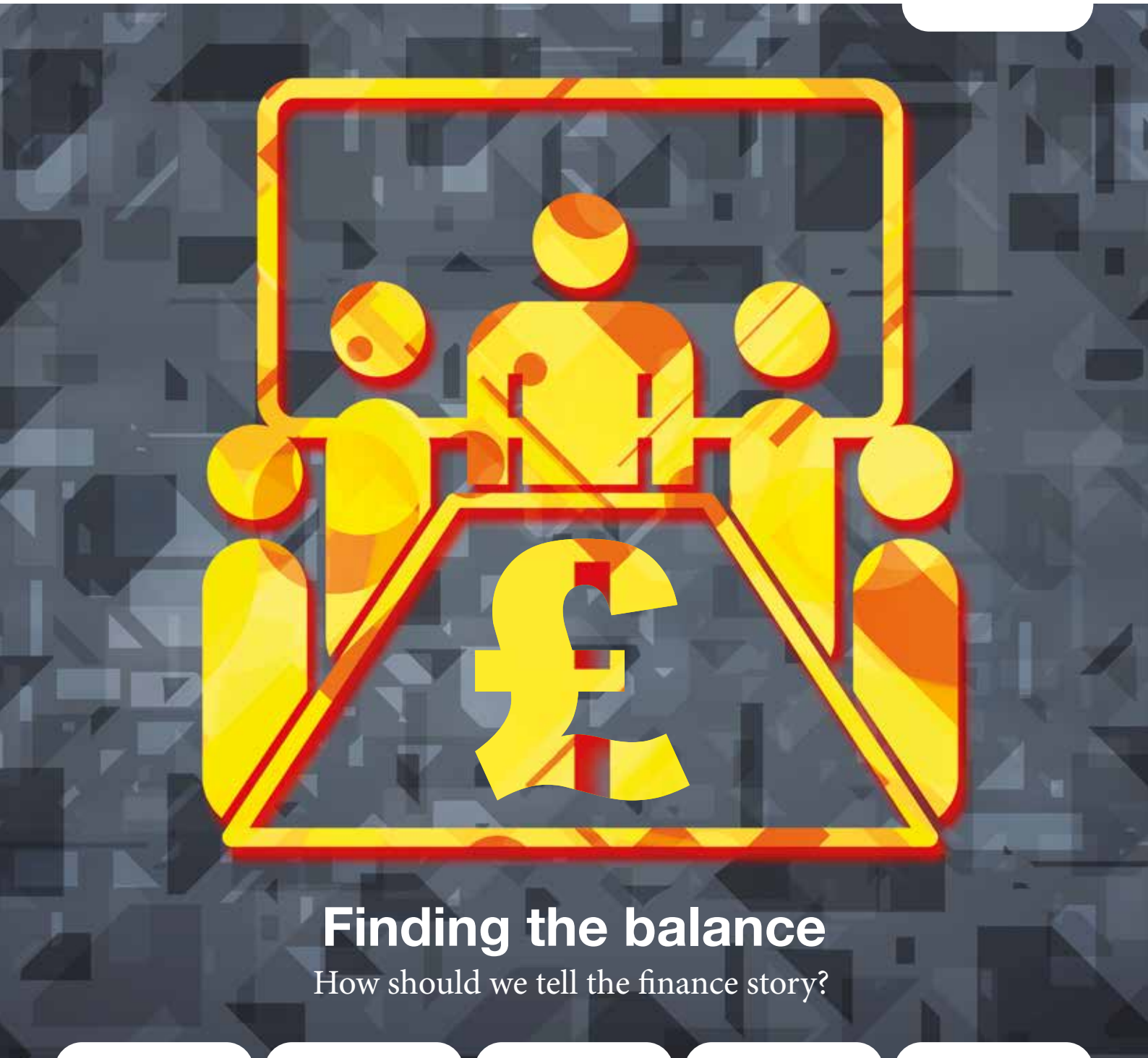

Finding the balance

How should we tell the finance story?

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Pressure mounts for in-year and spending review settlements

Comment
Huge agenda in run-up to integrated care board launch

Features
Population health management: the way forward

Features
Digital future: HFMA focuses on finance skills and knowledge

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News

NHS waits for key autumn funding announcements

By Seamus Ward

The next few weeks will see important announcements on NHS finances, as the service in England waits to hear details of its funding for the second half of the 2021/22 financial year, and its longer-term funding settlement in the government's spending review.

It is widely anticipated that chancellor Rishi Sunak will find further funding for the health service, though this could be linked to performance and the reintroduction of historical levels of efficiency savings.

Talks between the Department of Health and Social Care and the Treasury continued over the summer against a backdrop of calls from NHS thinktanks and pressure groups for more funding in the spending review – for areas such as social care, mental health, and the discharge to assess programme.

NHS Providers and the NHS Confederation have called for funding for the discharge programme to be made permanent.

An immediate pressure could be pay, with staff on Agenda for Change contracts, hospital consultants and salaried GPs awarded a 3% rise, backdated to 1 April. It is estimated that this will cost £2.2bn.

Senior managers will not receive a pay increase this year, and doctors in training and associate specialists have their own settlements.

Despite the unions' claims to the contrary, in the Commons health and social care secretary Sajid Javid acknowledged the 'economic and fiscal' challenges, but added that the award was 'expected to be a real-terms increase'.

Overall, the cost amounted to £1.9bn for Agenda for Change staff and some £300m for consultants, said Mr Javid.

It is unclear whether these figures include pensions and other knock-on costs.

NHS Employers asked if the government would fully fund the award. Although a 2.1% pay rise was assumed for this year in the five-year funding settlement, Covid spending has made health budgets unrecognisable.

Political journalists reported that Downing Street had said the pay rises would be funded from existing budgets, but this would not affect frontline care.

Aside from the pressure of funding the pay increase, health unions are currently consulting members on taking further action. They have said the hike represents a real-terms pay cut, with some economists forecasting 4% inflation this year. In Scotland, an average 4% rise for Agenda for Change staff has been rejected by some unions.

'Additional funding is always welcome, but finance staff also need early certainty on funding levels so that they can plan for the coming winter – which could bring so many variables in terms of Covid and non-Covid demand, including the risk of outbreaks of other respiratory illnesses,' said HFMA policy and communications director Emma Knowles.

IFS: Rishi Sunak (pictured) faces a 'tricky' spending review with little room for manoeuvre in the medium to long term

'There are other questions, including whether the pay award will be fully funded by the government, or will have to be found from existing budgets.'

The Institute for Fiscal Studies (IFS) said Mr Sunak faces a 'tricky' spending review with little room for manoeuvre in the medium to long term.

The IFS said the chancellor could afford a 'sizeable short-term giveaway' while remaining within the borrowing figures set out in the March Budget. This would likely be targeted at the public sector.

However, the IFS added that there was little space for recurrent budget increases, and sticking to current plans would mean spending up to £17bn less on public services than had been planned prior to the Covid crisis.

The NHS would be top of the list for additional spending, with Test and Trace, the vaccination programme, adapting to social distancing measures, and meeting the care backlog set to cost an estimated £7bn a year for three years, on top of existing spending commitments.

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The Nuffield Trust said NHS providers were already on uneven ground. Its analysis found that, after taking out Covid-related costs, trusts in England are on track to overspend on previously agreed funding by £5bn at the year-end. This was largely attributed to commissioner underestimates of activity levels and provider over-estimates of the efficiencies they could deliver. Non-delivery of planned efficiencies was compounded by the Covid pandemic, which had forced efficiency savings to more or less take a back seat.

Nuffield Trust senior policy analyst Sally Gainsbury, who conducted the analysis, said the government faced difficult decisions in the forthcoming spending review.

But she added: 'At the very least, the starting point for spending review discussions needs to be the NHS as it really is today, not the parallel fiction that NHS funders might wish it to be.'

She continued: 'These extra costs, beyond what the NHS anticipated, will exist even once the onslaught of Covid-19 finally stops.

'It is crucial that they are recognised in the forthcoming spending review. The NHS cannot expect the full gap to be wiped out by extra money, but the Treasury needs to be realistic about where the health service is starting from.'

Ms Gainsbury continued: 'Closing the gap by 2023/24, for example, would entail annual efficiency savings of around £4bn a year – more than twice the savings rate the year before the pandemic struck.

'Given that providers have to find around £1bn in efficiencies just to stand still each year, it would be more realistic to assume that at best it will take five years to close this gap.'

It is expected the payment arrangements for the second half of the financial year will be largely unchanged.

CCG board-level staff given reassurance on ICB transfer

By Steve Brown

Board-level members of clinical commissioning groups have been offered greater certainty over their futures in the move to integrated care boards (ICBs) next April.

It was previously announced that all CCG staff below board level were being given an employment commitment – 'lifting and shifting' into the new organisations on the same terms and conditions. The earlier guidance did not extend this guarantee to board-level positions.

However, a new *Human resources framework for developing integrated care boards*, published by NHS England and NHS Improvement, has now stated: 'It is crucial that, where possible, we retain our talented leaders and their experience and knowledge.' The framework said there was 'an expectation' that board-level staff would transfer to ICBs.

The aim is to agree alternative roles and retain as many people as possible. Where this cannot be achieved, the ICB would be responsible for implementing redundancy processes.

Healthcare Finance spoke to one CCG chief finance officer (CFO), who said this was in line with the messages being delivered locally – that there was a desire to retain the skills of senior commissioning leaders. But he added that it was encouraging to see it written down.

There are currently 106 CCGs that will transition into 42 new ICBs from next April under the current timetable. This implies significant numbers of board-level officers in CCGs potentially competing for a much smaller number of similar board-level roles in new ICBs.

In reality, however, there has been a degree of streamlining across the commissioning function ahead of the changes.

'The majority of CCGs have moved to a footprint that matches their integrated care system (ICS),' said NHS Clinical Commissioners chief executive Louise Patten. 'Some have moved by merging, others by adopting a single management team or just by more aligned working.

'Where mergers have not taken place, there is often some collaboration between finance teams across multiple CCGs. However, there may be a number of displaced CCG CFOs when ICSs appoint system finance leads.

"There are lots of opportunities and plenty of talented CCG staff, particularly in finance"

Louise Patten, NHS Clinical Commissioners

'There is no doubt that it will be challenging for some staff at board level,' said Ms Patten, adding that the HR framework provided helpful reassurance over their future.

'There are lots of opportunities and plenty of talented CCG staff, particularly in finance. They have very different skills to providers, because they oversee system finance, with one eye on the mountains in the distance rather than just the heat and light of service provision under the annual contract.

'There will be opportunities for provider collaboratives to share a level of transparency with local authority finance – to develop a profit and loss account at place level and look at how best to use the whole budget for health and social care to best support the population.'

Ms Patten said this would position finance much more in the role of health economics and population health management (*see page 20*).

'There will also be lots of opportunities at the system level for senior finance leaders to take a special interest in all the primary care or specialist care commissioning that is coming,' she continued. 'And there will be opportunities at supra-ICS level, where systems will have to co-ordinate services to get the scale where this makes sense.'

Interim guidance on ICB governance (see box), issued alongside the HR framework, states that a chief finance officer will be one of four executives required to be on the new boards as a minimum, working alongside a chief executive and nursing and medical directors.

While a chief executive designate should be identified by the end of November, the guidance gives ICBs until the end of quarter 4 to have selected their other executives.

However, CCG finance directors suggested the appointment process would need to happen much faster than this in reality, given the challenges of closing down in some cases multiple CCGs and establishing a completely new, more strategic organisation.

While many CCG functions will simply transfer to the ICB, there will be new processes and governance arrangements to implement, particularly around the relationship between the system and place-level working.

It is not clear exactly how finance teams will look in the new ICBs. For some activities, it is likely that numbers will need to expand. But in others – the devolution of responsibilities to place, for example – changes could reduce the numbers needed in central teams.

The timescale is tight, with a significant to-do list in continuing to monitor service provision, closing existing organisations and setting up new bodies. But system leaders are confident it can be achieved by April.

ICB governance

According to *Interim guidance on the functions and governance of integrated care boards*, integrated care systems exist to achieve four aims: improve outcomes; tackle inequalities; enhance value for money; and support broader social and economic development.

The new statutory ICBs are required to set out their governance and leadership arrangements in a constitution that will be formally approved by NHS England and NHS Improvement before the end of quarter 4. This can be based on a draft model constitution that has been developed centrally.

They need to plan how the ICB unitary board will be populated, with deadlines set for the appointment of chief executives (end of November) and the other principal board directors (end of Q4). They must also confirm plans to ensure commissioning functions are organised across the ICS footprint and develop a functions and decision map showing arrangements with ICS partners to support good governance.

ICBs will also need to set out the role of place-based leaders within their governance arrangements. And they must work with provider collaboratives to define their working relationship, including the participation in different committees.

• *See Stewards prepare for new start, page 8*

PCN management funds welcomed

Primary care networks (PCNs) will receive dedicated management funding under plans for the coming 18 months.

A letter from NHS England and NHS Improvement to primary care leads set out funding and new service requirements. NHS England confirmed the Investment and Impact Fund (IIF) – the incentive scheme that promotes PCN service improvement goals – will be worth £150m in the current year and £225m in 2022/23, but that new funding totalling £43m will be available for PCN leadership and management in 2021/22.

The funding will be allocated on the basis of the clinical commissioning group primary medical allocation formula, which includes adjustments for areas of higher deprivation. PCN clinical directors should recommend how management funding should be deployed, the letter said.

Clinical directors rather than commissioners should ensure the IIF is reinvested in services and staff, it said. 'PCNs need to know that if they achieve the goals, they can be certain that the funding will definitely follow.'

NHS Confederation PCN Network chair Pramit Patel welcomed the funding, adding: 'The introduction of dedicated funding for management resource is long overdue and will enable PCNs to put in place a more robust management infrastructure necessary to oversee the increasing amount of responsibility they are being given.'

Scots' £1bn recovery plan

By Seamus Ward

The Scottish government has set out a five-year NHS recovery plan, backed by £1bn of investment, which aims to prioritise the health and wellbeing of staff, and place innovation and technology in the forefront of service redesign.

NHS recovery plan 2021-2026 also pledges to increase inpatient and day-case activity through a network of national treatment centres (NTCs), which will provide elective procedures and diagnostic activity.

The original NTC – at the Golden Jubilee National Hospital – will be joined by six centres currently being developed, and two more units in Ayrshire and Cumbernauld.

The plan commits a further £70m to develop the two centres, on top of the £330m already allocated to the NTC programme.

A replacement for the Edinburgh Eye Pavilion will see the NTC network grow to 10 centres.

It is expected that the network will deliver an additional 40,000 elective procedures a year by 2026, and this will accelerate to 50,000 from 2026 onwards. Also, £29m will be targeted at removing diagnostic backlogs, with 78,000 additional procedures in the current financial year. Further funding will increase the procedures to 90,000 per year by 2025/26.

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The plan pledges £11m for a new international recruitment campaign over five years that will seek to recruit 1,500 NTC staff, and 1,000 primary care mental health staff.

The government also recommits to the targets in the *Integrated national workforce plan*, such as recruiting 800 more GPs by 2026.

Health unions are concerned about the ongoing impact of the pandemic on staffing levels, and urged the government to adopt a cautious approach to recovery. An additional £3m a year will provide enhanced wellbeing support, bringing overall funding to £8m a year.

To ease the pressure on A&E, urgent care will be redesigned using £23m, ensuring rapid access to a clinician by phone or video consultation. Services will be placed closer to people's home, and a new national Centre for Sustainable Delivery will pioneer better and more sustainable ways of working across NHS and social care, harnessing the benefits of technology and new treatments.

First minister Nicola Sturgeon (pictured) said NHS Scotland's recovery would exceed pre-pandemic levels. 'As we maintain our resilience against Covid-19 and other pressures, the Scottish government is providing targeted investment to increase capacity, reform the system and ultimately get everyone the treatment they need as quickly as possible.

'Tackling the backlog of care is essential and will be a priority. But we want to go further than that and deliver an NHS that is innovative, sustainable and stronger than ever before.'

HFMA launches membership study

The HFMA is aiming to develop a better understanding of the make-up of its membership to ensure the association is representative of the finance function as a whole.

The association has worked closely in recent years with NHS England and NHS Improvement, as well as Future-Focused Finance, to understand and improve diversity and inclusion in NHS finance departments.

Working with the Skills Development Network, it has amended its biennial finance function census to collect details of ethnicity alongside the data it has traditionally collected on pay bands, the type of organisation finance staff work in, and gender.

The next collection will be run next year – following a year's delay to enable the new census to reflect the system structures that will be in place from next April. However, while there is an improving understanding of the make-up of the national finance function as a whole in terms of gender, ethnicity and seniority, the HFMA cannot undertake the same analysis for its own membership.

'We have done some work to improve the diversity of our committees and groups, although there is more to do,' says HFMA policy and communications director Emma Knowles (pictured). 'But we don't know very much about the actual make-up of our membership beyond name, organisation, job title and contact details. This means we don't know how diverse we are as a membership. And we don't know whether our membership reflects the national function in terms of age.

'We are determined to be fully representative of the whole finance function and getting a better understanding of how our membership is made up is a key part of that,' she added.

The HFMA will be asking members to provide extra details over the autumn. No individual details will be shared with anyone else. And members can opt not to provide the additional information if they prefer.

News review

Seamus Ward looks at recent developments in healthcare finance

The NHS is still in the grip of the Covid pandemic, both in terms of the work needed to vaccinate as many people as possible, and to cope with the demand for care from those who become seriously ill with the virus. But on top of this Covid work, demand for non-Covid care is rising, with A&E attendances increasing and pressure to reduce elective waiting lists growing. And, as summer turns to autumn, health services around the UK will be wondering what lies ahead.

As always, funding will be a major issue. The NHS in England was yet to hear its funding settlement for the second half of the financial year (*see page 3*) as *Healthcare Finance* went to press, but services in Wales and Scotland have received additional finances to support both Covid spending and the cost of recovery.

In August, the Welsh government allocated an extra £551m in Covid funding for health and social care. Health minister Eluned Morgan said £411m will be spent supporting the ongoing costs of responding to the pandemic, while £140m will go to recovery of services and tackling waiting times. The ongoing costs include vaccination, testing, personal protective equipment, and meeting new infection control standards. The funding is in addition to £100m announced in May for the Welsh government's health and social services recovery plan.

The Scottish government allocated £380m in July to help health boards with the costs of the pandemic. It includes support for the Covid and flu vaccination programmes (£77m), the Test and Protect system (£90m), and personal protective equipment (£85.5m). The remaining £127m will be used to support additional staffing costs as the hospital sector recovers, as well as equipment, maintenance and IT. The government said further funding would be available as necessary.

Waiting lists in England could grow to 13 million – as health and social care secretary Sajid Javid recently warned – or higher, the Institute for Fiscal Studies (IFS) has said. The institute said seven million fewer patients than expected joined the waiting list between March 2020 and May 2021. Even if only two-thirds of these patients joined the list and the NHS was operating at 95% of pre-Covid capacity, waiting lists could easily exceed 13 million and keep growing, the IFS said. According to the June figures, there are almost 5.5 million people on waiting lists, though NHS England said the service was making progress on non-urgent care, despite a busy summer, with high numbers of patients coming forward and the Covid vaccination programme.

The move to integrated care systems (ICSs) in England increased at pace as the government published its *Health and Care Bill*. Joint working under pooled funding arrangements has been in place for years, and since 2015 principally through the Better Care Fund (BCF), which supports health and care integration to help people to stay at home and live independently. Almost £7bn has been committed to the BCF for 2021/22, including £4.3bn of NHS funding, £2.1bn from the improved BCF grant to local authorities and £573m for the Disabled Facilities Grant. The Department of Health and Social Care said the NHS contribution had increased by 5.3%, in line with the *NHS long-term plan* settlement. But the grants will remain at 2020/21 levels.

The Westminster government hailed a milestone in its hospital building programme as Mr Javid opened the £35m Northern Centre for Cancer Care in Carlisle. The cancer centre is one of the 48 hospitals the government has promised

The news in quotes

'I recognise it is a huge task just to get back to where we were before the pandemic. However, we must also grasp this opportunity to adopt new ways of working and create a sustainable health and social care system that can meet the demands of the future.'

There are improvement opportunities, despite the impact of Covid, according to Wales health minister Eluned Morgan

'The skill, determination and can-do spirit that NHS staff have shown in the face of the greatest challenge in the health service's history means we face the future with confidence.'

New NHS England chief executive Amanda Pritchard believes the service can overcome the tests ahead

'Our senior medical staff will continue to be the best paid in the UK. As well as rewarding them for their efforts in the pandemic, it will help to ensure NHS Scotland remains an attractive employment option for medical and dental staff.'

Scotland's health secretary Humza Yousaf sees a 3% pay rise for doctors and dentists as a win-win

'The Innovative Medicines Fund will significantly reduce the time it takes for the most promising new medicines to reach patients, including children and those with rare diseases, saving lives and giving many people hope for a healthier future.'

Health and social care secretary Sajid Javid hails the planned extension of the Cancer Drugs Fund model

SHUTTERSTOCK

NHS England's new chief executive is Amanda Pritchard – the first woman to be appointed to the post

by 2030 as part of its hospital building programme, the Health Infrastructure Plan. It was one of eight that had already secured funding when the programme was announced.

and introduce structural reform. A former chief executive of Guy's and St Thomas' NHS Foundation Trust and a career NHS manager, Ms Pritchard is the first woman to be appointed to the post.

Doctors and dentists in Scotland will receive a pay rise of 3% backdated to 1 April, health secretary Humza Yousaf announced. The award is in line with the recommendation of the doctors' and dentists' pay review body and follows the deal for Agenda for Change staff in Scotland of a minimum of 4% to all but the highest earners. Mr Yousaf said the award for doctors and dentists recognised their hard work and dedication over the past year.

Staying in Scotland, the government has opened a consultation on the creation of a new National Care Service (NCS). At a minimum, the NCS will cover adult social care, but the consultation document recognises that if a comprehensive care system is to be created, extending the scope to other services, including those for children and young people, should be considered. Social care minister Kevin Stewart said the government wanted to create a comprehensive community health and social care service for people of all ages. Local delivery boards will work with the NHS, local authorities and the independent sector to plan, commission, and deliver the services.

Amanda Pritchard has been appointed NHS England's new chief executive. Ms Pritchard, who has been Simon Stevens' deputy for the past two years, will lead the service's bid to recover from the Covid-19 pandemic, address a major backlog of treatment, transform service delivery,

The government's Infrastructure Project Authority (IPA) called for action on the project to deliver the new integrated single financial environment (ISFE) for England. In its annual report on major projects across government, the IPA said its overall delivery confidence assessment rating for the £300m ledger scheme is amber/green. However, it was currently rated red due to the need for sufficient resource in some key areas, such as commercial strategy and project management support. In April, the current ISFE contract – provided by NHS Shared Business Services – was extended to 2024 while its replacement is procured. The IPA also rated the New Hospital Programme, which aims to deliver 48 hospitals by 2030, as amber/red. The programme team had made progress setting up the complex scheme with robust governance, it said, but much remained to be done.

The Cancer Drugs Fund is to be replaced by a wider-ranging Innovative Medicines Fund (IMF), under NHS England proposals. The IMF will have ringfenced funding of £680m, and will seek to help patients with any condition to access the most clinically promising treatments. These treatments will include those where more data is needed to support the National Institute of Health and Care Excellence to make final recommendations. The existing cancer fund is worth £340m, and the expanded scheme will receive a further £340m to fast-track drugs.

from the hfma

As well as keeping members up to date on the latest pandemic developments in the Covid-19 update and Covid-19 reader, the association published regular blogs over the summer months.

In one blog, Patrick Mitchell, Health Education England director of innovation, digital and transformation, highlights the important role finance professionals can play in digital transformation in the NHS. Finance staff support the allocation of resources, monitor their use, and provide evidence of productivity improvements, he says. This underlines the importance of the new HFMA programme, supported by HEE, which aims to increase awareness among finance professionals and help them play an active role in delivering new technologies, he says (*see page 11*).

University Hospitals of Leicester NHS Trust respiratory consultant and HFMA trustee Sanjay Agrawal (pictured) says the NHS is now putting prevention at the heart of its planning, but finance staff must identify funding for these programmes within their local structures.

Wes Baker, Mersey Care NHS Foundation Trust director of strategic analytics, economics and population health management, blogs about the potential benefits neurodiversity, including dyslexia, can bring to NHS finance departments. And Bermuda Hospital Board chief financial officer Bill Shields delivers his latest postcard from the territory, reflecting on the differences in Covid response.

Finally, HFMA policy and technical manager Debbie Paterson looks at the year-end impact of the pandemic and the lessons the NHS can learn from the preparation of the 2020/21 annual report and accounts.

See www.hfma.org.uk/blogs

Comment

September 2021

Under pressure

Covid-19 is just one of the demands on the NHS

HFMA president Caroline Clarke

The country may be talking about the return to normality, with venues and restaurants now in full swing. But in the NHS we face a new normality, with Covid-19 treatment now part of business-as-usual.

Daily cases continue to be high – similar levels to those in late January. And daily admissions to our hospitals appear to be around 800 to 900 nationally, with over 6,000 beds given over to Covid-19 patients.

Despite a hugely successful vaccination programme, the pandemic is clearly not over – even if international events have temporarily grabbed the top of the news agenda. We are all too aware of this in the health service. However, our continued response to the virus is just one of the major pressures we face.

There is a huge focus on recovery and no-one should underestimate the scale of this task. There has been some great progress on the numbers waiting over a year to start treatment and on cancer check-ups. But the backlog of patients waiting to start treatment now stands at 5.5 million.

We face this while experiencing major pressure in our urgent care pathways. Across England, we averaged 70,000 A&E attendances a day in July, the highest level since winter 2019.

Beyond these immediate pressures we also face a further restructuring, with the move to integrated care boards from next April. Greater system working is clearly part of the solution. That is how we can optimise pathways that may cut off some urgent

Stewards prepare for new start

There is a huge amount to do to get new integrated care bodies ready for April, when the real work begins

Healthcare Finance editor Steve Brown

August's publication of guidance on setting up new integrated care boards (ICBs) from next April is undeniably helpful. But what it underlines most perhaps is the massive agenda facing systems in getting the new structures up and running.

The *Interim guidance on the functions and governance of the ICB* fleshes out some of the governance expectations on the new statutory bodies – a key part of integrated care systems – and sets out the minimum membership requirements for the new unitary boards.

And in the accompanying *HR framework for developing ICBs*, NHS England and NHS Improvement have provided some welcome reassurance for current board-level officers in clinical commissioning groups and ICS leads.

This confirms an 'expectation' that board-level staff will transfer to ICBs despite not being covered by the employment commitment that has been given to staff in positions below board level (*see news page 4*).

This may have been the presumption, but senior leaders – particularly in CCGs and including those in finance roles – were reassured to see this in black and white.

The NHS cannot afford to lose skills and staff because of a few months' uncertainty over specific roles and functions. There may only be 42 chief finance officer roles between the new statutory ICBs, but there will be a whole range of important future finance roles that will benefit from the experience built up in CCG finance teams in recent years.

The system is changing. The ICB role is being framed in terms of stewardship rather than commissioning – as the service looks to break even semantic links to the former commissioner-provider split and market behaviours. But commissioning skills and the finance skills that go with them will still be in high demand – whether at the system or place level.

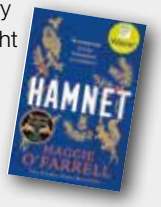
Determining the needs of a particular population and putting in place the right services to meet those needs will remain a core activity, wherever it is located.

So hopefully the HR framework will prevent the NHS losing valuable skills at a time when it needs them.

The current timetable suggests that ICBs have until the end of quarter 4 to appoint CFOs and medical and nursing directors. And even if these positions are filled more rapidly, it could take some time before other key finance positions are considered.

PRESIDENT'S PLAYLIST

BOOK I've just read Maggie O'Farrell's *Hamnet*. I never got to grips with Shakespeare and worried this might be too highbrow for me. But it's a gripping re-telling of the story of the person who might have been Shakespeare's son, after whom the play might have been named. I loved it.



MUSIC Our holiday playlist for our break at the end of August included some Go-Go's (including the original *Our lips are sealed* hit), Rufus and Chaka Khan (*Tell me something good*) and Arlo Parks (*Collapsed in sunbeams*).

• ***Send your suggestions to president@hfma.org.uk***

"We urgently need clarity on funding, so we can map out the rest of the financial year"

care demand by moving interventions and support further upstream. That's also how we can tackle some of the wider determinants of health and start to address health inequalities – a further challenge underlined during the pandemic.

Changes such as these require time and headspace to implement, and transformation is difficult to take forward when clinical and support staff are understandably focused on the here and now – as well as exhausted from a difficult 18 months. Planning for these challenges is essential, but that is difficult when we don't yet have certainty on our funding levels for the second half of the year.

We understand the extreme financial challenges facing government, with competing demands from numerous departments, all with a good case for their claims. But we urgently need clarity on funding, so we can map out the rest of the financial year.

Beyond this, we must hope the spending review provides a realistic multi-year settlement for health and social care. The move to system working offers exciting opportunities to integrate care for patients, but it will be entirely dependent on having a realistic level of funding in both sectors. Without the promised fix for social care, system working will be starting on weak foundations. And funding has to be targeted at the long-term recruitment and development of NHS staff.

With the right settlement, we must also ensure we have an appropriate mechanism for moving funds around the system. The accelerated switch away from the national tariff should help systems to move funds behind revised pathways. And there are proposals for a default payment system based on a core fixed price for agreed activity, with variable elements to support elective recovery.

However this is taken forward, we need to keep it simple, giving systems the maximum flexibility to meet their challenges and ensuring time is spent on recovery and transformation, not on negotiation and contracting.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

"Hopefully the HR framework will prevent the NHS losing valuable skills when it needs them"

There is an immense agenda to address by next April. Systems, and the structures within them, are likely to look quite different from area to area, reflecting the different arrangements that have been put in place in preparation, and a determination to be flexible.

Places will be key in how ICBs operate. Larger ICSs may have multiple places, while smaller systems may have a single place and it is thought that ICBs will be encouraged to delegate as much as possible to place.

This could take a number of forms. In some cases, this could involve delegating funds to a provider collaborative through a prime provider or alliance contract, with the ICB taking a definite stewardship role.

Or alternatively, and where provider collaboratives are not yet ready to take delegated responsibility at place, some form of accountable officer could be appointed at place-level to set up local decision-making arrangements.

Getting the structures ready with the right governance and assurance is only the most pressing demand. The real work starts once the structures are set up.

There is a big push to start to address health inequalities, and this implies moving funds around within systems and making changes to place-based allocations.

The NHS is also moving to a more trust-based system and away from the counting and billing under national tariff arrangements.

This should be accompanied by a switch to key outcome-based contracts, which have been talked about for years but remain few and far between.

The to-do list for the new 'stewardship' organisations is massive, both in the run-up to next April and beyond.

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Mi Healthcare 25 years

SHUTTERSTOCK

Switching it up

New technologies could be crucial in NHS recovery – and finance is vital in this. A new HFMA initiative, supported by Health Education England, aims to increase finance managers' awareness and help to drive value and efficiency in digital transformation. Seamus Ward reports

During the pandemic, we have witnessed the power of genomics as a tool to support healthcare professionals, with the discipline used to identify Covid-19 variants and track their spread.

Knowledge of the genome was crucial in the development of messenger RNA (mRNA) vaccines, such as those developed by Pfizer BioNTech and Moderna. The potential of genomics is huge – it is already used to tailor chemotherapy for cancer patients, increasing its effectiveness and reducing side-effects – and is an example of technological developments that will revolutionise both healthcare treatment and prevention.

Genomics was one of three areas highlighted in 2019's influential Topol review, *Preparing the healthcare workforce to deliver the digital future*, which recommended actions to ensure the NHS has the skills to be a world leader in using digital technologies to benefit patients.

The review also singled out two further areas – digital medicine, and artificial intelligence (AI) and robotics. While digital medicine could include telemedicine, smartphone apps, and wearable sensors, AI and robotics could be used in surgery, automatic image interpretation and population predictive analytics.

The review predicts that, underpinned by data, within 20 years these three high-profile technologies will converge and complement each other, allowing NHS staff to deliver more personalised care and disease prevention.

The NHS must get ready now to ensure it makes the most of digital's myriad opportunities by training its clinical staff and preparing non-clinical workers, including finance staff.

To this end, the HFMA has launched a 12-month programme, supported by Health Education England (HEE), to raise awareness among finance staff of how digital technologies can transform services and drive value and efficiency.

But why target finance staff? Patrick Mitchell, HEE director of innovation, digital and transformation – who was also senior responsible officer for the Topol review – says: 'It's to recognise the central place finance takes in the NHS – finance staff hold the public purse and help

Digital programme

Delivering value with digital technologies is a 12-month HFMA programme, supported by Health Education England. It aims to raise awareness of the potential of digital technologies to transform the delivery of healthcare, and enable finance to take an active role in supporting the use of digital technology to transform services and drive value and efficiency.

Adoption of the technologies could lead to higher quality, more personalised care, as well as better outcomes for patients and greater efficiency. They could also help patients become more involved in their care and the maintenance of their wellbeing.

The programme will include briefings, roundtables and blogs, HFMA Bitesize training modules and more.

The new HFMA Delivering Value with Digital Technologies Award – which will be presented at the HFMA conference in December – will recognise innovative use of technology.

• For details go to the HFMA website at hfma.to/mof

plan resources and how they are deployed. Finance has to be central to this as the digital agenda will be driving productivity, the use of data, the use of AI, and the use of digital healthcare. Finance has got to be part of this to understand the agenda, and what it means, so it is better able to influence how it is deployed.'

Mr Mitchell adds that finance staff will be involved in the early stages of business cases. 'They could stimulate business case production alongside clinicians; asking the challenging questions as to why they are not using data to support clinical decision-making; or talking to radiologists about what kit they need to buy to use AI-driven diagnostics to support their workload. If finance is not a part of this, there will be an impasse – clinicians will want to do it and we really want finance staff to be there with them.'

He insists the programme is not just for senior finance practitioners. 'It's also for finance business managers working on the shop floor with clinicians and service managers. I hope they get excited about it, and there is some co-production between finance people and those they work with in hospital and community settings, and, I would like to think, primary care finance teams.'

King's Fund fellow for digital technologies Pritesh Mistry agrees that finance staff can be powerful advocates for digital transformation. 'There are different phases of transformation, and if you can have the support of finance – with robust policies and the right processes, and a shared understanding that some ideas will turn out to be a dead end – that's really powerful. If you can have data available to strengthen the outline business case for transformation, for example, and then build that into forecasting, this is hugely valuable in making sure that the management support is there for digital transformation.

'A lot of people don't realise that IT needs considerable maintenance and this requires investment.'

Mr Mitchell says digital transformation has many facets for the NHS and should be primarily about designing services by putting the patient at the centre. To support this, HEE must equip learners and those who facilitate learning with the digital skills so they can be part of the redesign journey.

He continues: 'The retail sector has used a methodology that tries to put the product in people's homes, or as close to the home or service user as possible. That's different to the historical way the health service has designed itself, which has been around the institution and the healthcare professional and their requirements, and not necessarily directly the patient.

'From an HEE point of view, we are looking to be a Digital First organisation ourselves and use digital transformation to better manage the needs of those who we serve – the trainees and learners in the health service; and the educators who work with us to teach those trainees and learners. We must make sure the digital infrastructure is designed around their needs and the way education is delivered.'

Digital transformation is not just about the IT, which in itself provides only the infrastructure. So it needs to involve more than technologists – those responsible for the IT – and also include those who manage knowledge, those working with data, and informaticians.

While 'big box' solutions that often rely on data, such as the electronic patient record, can be individual elements of digital transformation, they are not the whole story, Mr Mitchell insists. 'Data and how it is used, especially with AI technology, can be crucial for helping support future higher productivity. We will be using data differently – to drive a different kind of clinical decision-making, in trend and predictive analysis, for example, where we are already seeing that in the use of AI in genomics and cancer.

'But that is only one component of how the digital agenda is going to drive the future of health service delivery. We have to look in the wider sense in terms of digital healthcare, AI and robotics, and genomics, which were the three areas identified in the Topol review.'

Mr Mitchell says genomics will drive a new wave of development in diagnostics and treatment. Although strictly speaking not a digital technology, it relies on data, so it would have been remiss not to include it in the Topol review, he adds.

Bigger picture

Digital transformation does not always mean cutting-edge tech with the 'wow' factor. While advanced technologies will be important, they will be complemented by well-known gadgets and tools that are being used in new ways.

The pulse oximeter, for example, which can be bought for a few pounds, is being used to monitor Covid patients at home (*see box, facing page*). And drones have been used in remote parts of Scotland to deliver up to 3kg of medical supplies, lateral flow tests and personal protective equipment. The journey of up to 40 miles takes 15 minutes by drone, compared with more than a day by road and ferry.

The King's Fund's Dr Mistry says digital transformation is moving forward. 'There's something happening in terms of digital tools being used in new ways. That's not unique to healthcare – in a lot of sectors there's a lot of retooling and repurposing of digital technologies.'

In part, this is being driven by a generational shift, due to the advancement in technology with the advent of smartphones and cloud technology. That changes how organisations work – it leads to things like remote consultation and a much bigger pool of clinicians, for example – now you can go to people nationally to locum for you remotely.

'With 80% of people having smartphones, the starting point changes – what does that mean for healthcare; how do you communicate with patients? Not only does the patient have a communication device in their hand, but it can also be a diagnostic tool. It will be interesting how this platform continues to develop.'

Dr Mistry adds that the benefits of AI and robotics will be harnessed, and the analysis of data – which is closely allied to AI – could transform healthcare. 'The huge benefit of digital is that you can measure so much more. But it is dependent on what lens you put on it. There's also a

> **"With smatphones, not only does the patient have a communication device in their hand, but it can also be a diagnostic tool"**
> **Pritesh Mistry, King's Fund**

question of how much data is useful.' This is particularly the case with finance.

NHSX head of innovation Yinka Makinde, who recently led an HFMA webinar as part of the *Delivering value with digital technologies* programme, says that though investment in new technology has increased over the past decade, 2020 was the defining year for the role of tech in delivering healthcare. Technology became central to the delivery of services as the NHS responded to the Covid pandemic.

'I have theories why it accelerated. There are three areas. The first was that there was a lack of capacity to deliver routine care. It stimulated us to think differently about how we deliver care, and jolted us into action, to adopt, for example, virtual consultations and remote monitoring technologies, almost instantly,' she says.

'Second, there was a significant injection of funds from the centre and also locally through a reprioritisation of spending. Third, for the first time, digital was seen as a need to have, not a nice to have. Its value was acknowledged, and it was realised.'

Ms Makinde says that in 30 years' time, personalised disease detection and treatment will focus on early detection, health monitoring and targeted treatment. She highlights three technological developments that will have an impact on these areas:

- **Nanorobots** Ten times thinner than the width of DNA, they could be used to detect disease early and to deliver therapeutic drugs precisely where they are needed. Nanobots can already detect cystic fibrosis and sickle cell anaemia early.
- **Continuous health monitoring** Used, for example, through smart homes and wearables, these provide alerts if a person's wellbeing changes, giving early warning and, potentially, better outcomes as a result.
- **Gene editing** This will move beyond the current focus on cancer and dementia to new ways of targeting treatment of other diseases.

Good data will be key to ensuring the success of these developments, so it is crucial the health service gets the basics in place, she adds.

The NHS had been gearing up for digital transformation before Covid, but the pandemic, and the need for the service to recover from its impact, means technology, new and old, is being used to design more efficient and effective pathways around the patient.

Finance staff must be aware of the opportunities so they can support best-value, high-quality services.

Preventing admissions

Daniel Hodgkiss, assistant programme manager (patient safety) at West Midlands Academic Health Science Network, hopes the pulse oximeter – the clip-on-your-finger blood oxygen monitor (pictured) – will one day be as common in the home medicine cabinet as a thermometer.

This relatively simple and inexpensive piece of technology is the foundation for the region's pulse oximetry@home (step-up facility for Covid positive patients) and Covid virtual wards (step-down care for patients discharged from hospital).

'In the early days of Covid, we realised patients were rapidly deteriorating and dying because Covid-19 causes silent hypoxia, where their oxygen sats were reducing quickly, which wasn't being detected,' says Mr Hodgkiss, who has responsibility for the managing deterioration safety improvement programme across the region.

This risk of silent hypoxia can lead to hospital admission. But the step-up and step-down facilities aim to support people in their own home, identifying patients at greatest risk of poor outcomes early by monitoring oxygen levels, and only admitting patients most in need of hospital treatment.

Patients are monitored up to three times a day for up to 14 days, including days five to seven and nine to 11 when patients' condition can deteriorate. Initially, practitioners called the patients for their readings, but over time an app was

developed. Calls are still made to those unable to use the app. If a patient's oxygen saturation drops to 93% or 94%, their GP is notified and may do further tests, such as the sit-to-stand test to determine oxygen saturation. At 92% or below, the practitioner will arrange a hospital admission. This ensures that the patients with the greatest need are being treated in hospital.

Home pulse oximetry monitoring was nationally mandated for all clinical commissioning groups in October 2020, and nationally the NHS purchased 400,000 pulse oximeters. West Midlands accelerated the work, in partnership with the wider system, setting up pulse oximetry@home in all CCGs by December. Virtual Covid wards were established by January. While the home pulse oximetry project is run by primary care, virtual wards are led by secondary care, sometimes with primary care support.

While funding for virtual wards is drawn from existing budgets or Covid response allocations, pulse oximetry@home is financed by the GP expansion fund set up to increase capacity during Covid. As well as home pulse oximetry, the fund (worth £270m since November 2020) supports six other priorities.

The amount spent on oximetry may become clearer once a national evaluation report is published this month. But Mr Hodgkiss says the local impact has been positive. 'We had 4,000 patients in the virtual wards and oximetry@home programmes, and if only 3%-5% were admitted or readmitted – that saves well over 3,000 patients going into hospital.

'The Covid virtual wards have reduced length of stay, increasing acute capacity. Patients are feeling more confident – they can stay at home; they didn't want to go to hospital as the perception was that if you did you would die of Covid. Patient satisfaction overall is tremendously high.'

The reductions in bed days potentially suggest significant savings. 'But savings in the acute setting can lead to costs somewhere else in the system,' he adds.

NHS England is working on expanding pulse oximetry, through the NHS@home programme, to prevent deterioration in patients with other conditions, and establishing non-Covid virtual wards, focusing initially on respiratory conditions to combat the rise in infections such as RSV (respiratory syncytial virus, which can be serious for infants and older adults).

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Telling the finance story

Financial reports are central to giving a board a robust understanding of the organisation's financial position. However, the information needs to be delivered in a way that is easy and quick to understand, finding the balance between too little and too much detail. A recent HFMA roundtable, supported by NHS Shared Business Services, aimed to identify the key components of a good report. Steve Brown reports

Financial information is crucial for boards to be able to take decisions to steer their organisations. But what level of detail should be included and how should it be presented? Answering these questions and more was the challenge taken on earlier this year by an HFMA roundtable.

Financial information is vital to enable boards to take decisions based on value – taking account of quality and outcomes alongside the resources consumed.

It not only has to be correct, it also has to be presented in an accessible way that enables executives and non-executives to understand the key numbers. And importantly, it has to be put into context. What are the key numbers that boards should look at? And what does it mean if those numbers change?

The roundtable was supported by NHS Shared Business Services, which produces the financial data for inclusion in the board reports of all clinical commissioning groups and a number of provider bodies – and will provide its finance and accounting service to the new integrated care systems from next April.

The roundtable brought together finance directors and chief finance officers from providers and commissioning bodies with those tasked with producing their own organisation's monthly board reports, as well as non-executives, representatives from NHS England and NHS Improvement and the National Audit Office (NAO).

Perhaps the first question that needs to be answered is: who is the audience for financial reports? There are a wide range of interested parties as well as the obvious board members, including regulators, patients, staff, the wider system (more of which later) and the press.

If being addressed directly, all these different audiences might prefer to see the information presented in a slightly different way. However, attendees were clear that the focus had to be on meeting the needs of board members.

HFMA ROUND TABLE

'The main audience has to be the unified board, so that it can take assurance from what is being presented to it and understand if the organisation is achieving what it is required to achieve,' said Barbara Gregory, former finance director and currently a non-executive director of Somerset NHS Foundation Trust. 'The meetings are not public meetings after all, but meetings in public.'

Reports vary across the NHS in terms of the detail provided. Shirley Martland, associate director of financial services and payroll at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, said too much information risked 'information

overload, with readers switching off and becoming overwhelmed.'

But while excessive detail could mask the few key issues on which the board should be focused, short reports can simply not provide enough depth of information to understand what is going on.

Simon Currie, director of financial planning and delivery at NHS England and NHS Improvement, said there was a challenge in reconciling competing requirements.

'Whatever is written in board papers needs to be brief, but you need to put enough in so readers can actively challenge it,' he said. He suggested there should be a short standard board report each month with a rolling programme of deeper dives into other areas.

However, the board only formed part of the scrutiny process, he added. 'Part of the challenge process happens in board sub-committee meetings, such as the audit or finance committee, where you can present a greater level of detail to the finance specialists.'

Keep it simple

Language is clearly vital. Ian Turner, HFMA director of finance and a non-executive director at Devon Partnership NHS Trust, said clarity and simplicity were the watchwords.

'Finance has an additional challenge to other parts of the NHS in terms of communication with NEDs,' he said. 'They have to get their heads around the language of the NHS and that can take years.

'But on top of that, some NEDs won't understand the language of finance. So, it is about keeping it simple and using all the tools at our disposal – such as graphs, pie charts and tables.'

Across the NHS there are terms that are used often but which have different meanings in different organisations. Terms are even used to mean different things in different contexts by the same organisation. Run rate is an example of an ambiguous term that has been highlighted before.

So, terms need to be crystal clear and well defined. Again, complete clarity is needed when describing financial performance – are the under- or overspends compared with plan or an absolute position?

CCGs report their drawdown of historic surpluses in different ways, making comparisons across organisations difficult. Even presentational conventions such as the use of brackets for negative amounts would benefit from standardisation across the service.

Ms Gregory said that, with her non-executive hat on, what she likes to see are 'short explanatory sentences interspersed with small tables that pick out headlines and key messages'. Too much text can be impenetrable, and pages of tables fail to highlight the key numbers that the board should be looking at.

"We should be promoting use of SMEs in local health systems. And the best thing we could do is pay them on time or early"
Adrian Snarr

By providing too much detail, the danger is that nothing gets looked at – especially in the context of wider board papers often taking on telephone directory-like proportions.

Ms Gregory said she would also like to see more information about the costs of services, with the change in payment regime moving the focus away from income.

'We are pushing now to have more visibility of how divisions within the organisation are actually doing,' she said. 'It is difficult to turn them into profit centres in the current environment, but we are beginning to look at them again as cost centres and ask how we can get assurance that they are working effectively.'

Focus on variation

Sam Riley, deputy director of intensive support at NHS England and NHS Improvement, argued for the inclusion of graphs. She said statistical process control (SPC) offered a better way for NHS bodies to analyse and present data, compared with traditional RAG (red, amber, green) rating approaches.

SPC looks at data over time and recognises natural variation so that those monitoring performance can focus on the variations that really merit investigation. This, she suggested, is what boards need – something that helps them to quickly identify the issues that must be addressed and where decisions should be taken, and to avoid overreacting to random data changes.

Born in the manufacturing industry, the technique is increasingly being applied in healthcare and Ms Riley, who leads the NHS *Making data count* initiative, believes it has a role in helping boards to understand if their organisations are making the most effective use of resources.

'Early work in trusts around finance using SPC is helping to start to answer that question,' she said. The Shrewsbury and Telford Hospital NHS Trust was applying SPC to finance and workforce datasets, helping them to see things they would previously have been unsighted on. 'For example, they were able to see that they were providing lots of agency cover for junior shifts, which is something you wouldn't want to be seeing,' she said.

Similarly, Maidstone and Tunbridge Wells NHS Trust had started using the approach to look at nursing spend per occupied bed day over time.

Numbers needed to be provided with context, said Stephen Sutcliffe, director of finance and accounting of NHS Shared Business Services. So don't just report what the number is, but explain the implications.

'The "so what" is vital,' he said. 'Reporting a reduction in cash held on the balance sheet could mean that you are not paying small and medium-sized enterprises (SMEs), for example,' he said. The consequences of the numbers should be explained, he said, adding that timeliness of reporting was also important. 'We have clients who report on day one and clients who report on day 12. I see no reason for such variation.'

Connected thinking

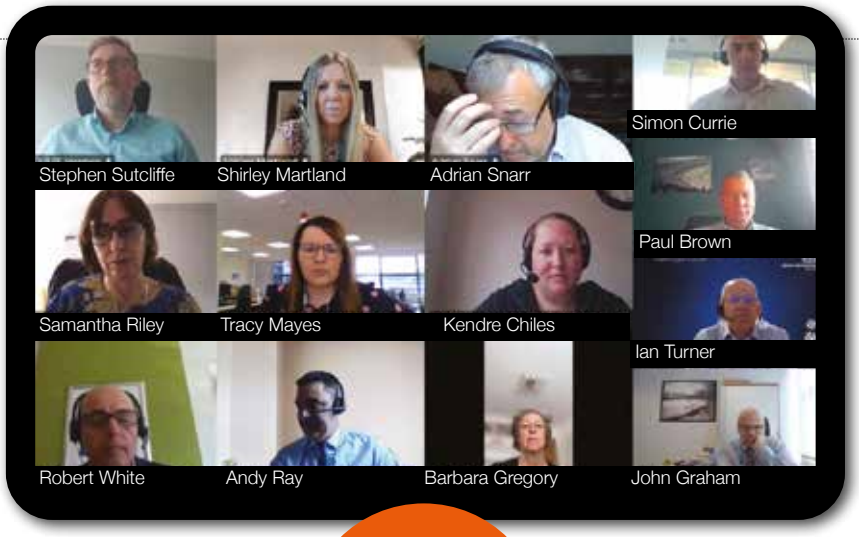
Ms Martland said one of the problems with board finance reports was that they tended to report everything in isolation – particularly treating income and expenditure separately from the balance sheet and capital.

'If we are telling the story, the reader needs to understand everything that is happening across the organisation,' she said. 'For instance, we might report that we are not achieving cost improvement programme (CIP) targets, but provide no indication of how that will impact on cash in the future months and lead to a decline in our cash position.'

Kendre Chiles, assistant finance director, financial services, at University Hospitals of Derby and Burton NHS Foundation Trust, is responsible for preparing the balance sheet and cash paper for the trust's finance and investment committee. She said there is a significant focus by the committee on the income and expenditure position, which wasn't wrong given its importance in providing key financial information on trust operations.

So, with less attention given to the balance sheet and cash, her challenge was to present the key information in as concise, engaging and understandable way as possible.

'It is important it gets the airtime,' she said. 'The integrity of the balance sheet is an indicator of the robustness of the income and expenditure position presented.'



HFMA ROUND TABLE

Participants

- Paul Brown, Staffs and Stoke CCGs
- Kendre Chiles, University Hospitals of Derby and Burton NHS FT
- Simon Currie/Samantha Riley/Adrian Snarr, NHS England and NHS Improvement
- John Graham, Stockport NHS FT
- Barbara Gregory, Somerset NHS FT
- Shirley Martland, Wrightington, Wigan and Leigh Teaching Hospitals NHS FT
- Tracy Mayes, NHS East Riding of Yorkshire CCG
- Andy Ray (chair), Mid and South Essex Joint Commissioning Team/ HFMA Accounting and Standards Committee
- Stephen Sutcliffe, NHS Shared Business Services
- Ian Turner, Devon Partnership NHST
- Robert White, National Audit Office

The balance sheet could be the 'canary in the coalmine' for where there are emerging financial challenges for an organisation, Ms Chiles added.

Her short – five or six page – report includes a condensed, summary balance sheet and cash flow report at the front and a cash table showing cash by month.

'If you are a challenged organisation, the key isn't the cash balance but whether you are drawing down the support you thought you would,' she said. 'If you've hit your plan on cash every month, but you are drawing down twice as much cash to achieve that, there is an underlying problem. That is what I want board members to focus on and question.'

The trust has recently introduced trend analysis to the report, showing how invoiced debt and accrued debt and invoiced cost and accrued cost are moving.

'That has allowed the NEDs to question whether these metrics are going up or down and what is driving that,' she said.

In the balance

The roundtable debated the importance of the balance sheet in the NHS and whether it should be subject to more scrutiny. NHS England and NHS Improvement have overseen a re-engineering of balance sheets across the service over the past year or so, shifting more cash into the provider sector. And their director of financial control, Adrian Snarr, said that the centre was likely to take a greater interest in future in how providers were using their improved cash position.

He highlighted the NHS's poor reputation for paying suppliers on time – behaviour that developed when providers' cash resources were low. Last year, the Cabinet Office issued guidance encouraging early payment of critical suppliers during Covid to keep cash flowing in the economy and protect against unnecessary supplier failure during the pandemic.

Mr Snarr said this should also be a key focus for boards – and not just because of Covid, but as a way of supporting local economic recovery. 'We should be promoting use of SMEs in local health systems,' he said. 'And the best thing NHS bodies could do is pay them on time or pay them early.'

The centre will be keeping a closer eye on this in future, both for recovery purposes and because it needed a good understanding of cash flows for discussions with the Treasury.

The national bodies are in discussion with NHS SBS about how they can track cash better and encourage organisations to pay on a more timely basis.

In terms of balance sheet reporting more generally, roundtable chair Andy Ray – chief financial officer of Mid and South Essex joint commissioning team and chair of the HFMA Accounting and Standards Committee – said he championed old-fashioned metrics, such as the percentage of invoices paid on time and current ratios, as providing a truer indication of organisation financial health.

'Normally, one of the first red flags of an organisation in trouble is that it stops paying suppliers on time,' he said. 'It often indicates an underlying problem. Including the payment percentage in board reports, along with the movements over time, should raise questions.'

He suggested that a cash dashboard, such as the one developed at Barking, Havering and Redbridge University Hospitals NHS Trust – an idea from stress-testing banks – provided an opportunity to flag up warning signs to non-finance leaders. 'It is hard to hide things on the balance sheet,' said Mr Ray. 'If you are accruing income that isn't real, you end up with aged debtors and creditors.'

"Work with SPC is helping boards understand if their organisations are making the most effective use of resources"
Samantha Riley

Spotting problems

While he acknowledged that some recent cases of financial problems at NHS providers had not been spotted by boards, auditors or the regulator, problems may have been found if different metrics were being looked at.

However, he acknowledged that board members should be provided with easily understandable reports and trained in what to look out for.

Mr Currie said NHS England and NHS Improvement had regularly looked back at financial problems in organisations to understand if they had missed early warning signs. But so far, he had not identified in the data reported anything that would have highlighted the issue. As a result, he said, the centre was exploring increased scrutiny of submitted reports – and in particular using the balance sheet and cash to spot income and expenditure problems. He added that there was a role for NEDs in providing appropriate scrutiny.

The way that the NHS is performance managed on a strict annual basis – with no real opportunity to deliver goals over a longer term also gave board reports an overly annual focus, according to John Graham, finance director at Stockport NHS Foundation Trust. They tended to be about

how the organisation was doing this year, not how it was doing against its long-term goals.

Responding to the concerns about the late emergence of issues, Mr Graham asked: 'How much has the management of control totals at organisation level and system level played into this? We are managed on performance at 31 March and the system congratulates itself on achieving a year-end position and then we move on to the next year.'

Board reports should be focused more on the underlying position and not the simple year-end snapshot.

Mr Snarr pointed out other red flags boards should look out for, in particular the auditor's ISA 260 reports. 'There is information out there from auditors and there's a risk that organisations are quite dismissive of this,' he said.

They sometimes disregard the findings, blaming the auditor for 'being picky' or 'risk averse'. 'But actually, there are often early warning signs in those external audit reports, and boards should be encouraged to embrace them and challenge the auditor or the finance director appropriately.'

Ms Gregory said the response to highlighted issues was key. If an organisation chose to treat the issue as a risk rather than a problem, it might still lead to no action being taken. The SPC approach might help to distinguish issues that need to be treated more seriously because of a poor trend over time.

But it was important for the finance board paper to be locked into the board assurance framework and for the paper to address the objectives and risks in the framework.

The key, according to the NAO's Robert White, was to ensure that NEDs had the right indicators in place to tell them if things were going off track and that they knew how to interpret the indicators. However, he also wondered if enough research had been done to look at the non-financial indicators that drive financial performance. He accepted it was not easy to make linkages – for example, between length of stay, utilisation or capacity and financial performance – but, given some of the problems with getting timely financial data, he asked: 'What indicators could we monitor that the money follows?'

Mr Graham agreed it was possible to get an idea of what was coming financially by tracking the big financial drivers. 'At Stockport, we look to collect information on a weekly basis around any movements in use of bank or agency staff,' he said. 'And on non-pay and some drivers around theatres and orthopaedic specialties, we look to see what's been on the order book, what activities have been delivered and whether that's affected our use of stocks. So there are things you can use that give an indication of what may happen when you get the formal reports.'

"The ability for NHS England and NHS Improvement to report on every CCG today, and in future every ICS, is a key benefit for ISFE"

Stephen Sutcliffe

System thinking

The roundtable also discussed the implications for financial reporting of the move to integrated care systems (ICSs).

'Most of our conversations have been about organisations,' said Paul Brown, chief finance officer of Staffordshire and Stoke Clinical Commissioning Groups. 'But the future is about systems, and financial reporting for systems will need to be quite different. It is about reporting on the costs across the whole patient pathway – that's what boards need to be focused on. And we can only do that properly if we look across the whole pathway, including the thorny issue of what is spent in social care.'

He added that the move to systems would also require organisations to change their own board reports. 'To make reports meaningful to our organisations, we have to not only talk about the organisation, but about how that organisation fits alongside others in the system and how collectively we are managing the cost of patient care and maximising the clinical output and quality,' he said. 'That is quite a different way of looking at it.'

Tracy Mayes, deputy chief financial officer (finance, contracts and procurement) at East Riding of Yorkshire Clinical Commissioning Group, said ICSs would have a responsibility to look at provider board reports. 'That gives a new lens on provider board reporting,' she said. 'They could have risks in there that could take the system down, so the board report comes into a new level of focus for everybody.'

In terms of board report audiences, she said this felt different to having a collection of a single organisation's executives and NEDs sitting around the table.

There has been much talk about the importance of collaboration in system working. But the simple act of board reporting would demand a different culture around transparency and open book accounting, which may counter some of the behaviours developed during the payment by results era.

Ms Mayes agreed that systems would need to focus on whole patient pathways and underlined that addressing health inequalities would be a major priority for the new ICSs. To do this, boards would need to understand how resources were being spent at system, place and neighbourhood level, which would place new demands on financial board reporting.

There will be technical challenges too. NHS England and NHS Improvement to date have done little more than consolidate bottom lines of organisations in systems to get a system level finance view. 'But we are starting to look at how we properly aggregate those numbers,' said Mr Currie, 'and eliminate the trading balances between commissioners and providers to try to give a proper close-to-consolidated view of where money is being spent, taking into account inflows and outflows.'

Being able to identify the actual money being spent in the system would be vital if systems were going to explore changes around allocative efficiency, he said. But he acknowledged that the centre did not want to create an approach that was so complicated it added a week to the reporting timeline. 'It needs to be slick,' he said, 'while doing more than just adding the bottom lines, which will only give rudimentary information.'

"Given some of the problems with getting timely financial data, what indicators could we monitor that the money follows?"
Robert White

Mr Snarr added that simply adding cash balances together doesn't work. 'CCGs draw cash in and providers hold cash until it is spent – that read across doesn't tell us anything meaningful as a metric,' he said. 'So we need to understand what the value-add indicators are at a system level.'

The complexity of the NHS provided other challenges, he said. Some organisations had established subsidiaries and were providers of shared services in a major way, bringing cash into the system. 'Should you disaggregate that from the ICS or not?' he asked. 'I don't think you can.' He added that specialist trusts providing services for patients from across the whole country provided further complications in establishing meaningful financial numbers about what is being spent within systems.

Mr Brown agreed about establishing a proper understanding of what was being spent and where. In Staffordshire, about 50% of acute activity flows are outside its system. So while system-level finance reporting will be important, patient flow reporting that was system agnostic would also be needed.

Ms Chiles said developing a meaningful financial picture across the system would be challenging. 'Every organisation holds its information in its own way, on its own platform and in its own chart of accounts,' she said. 'So there is a real risk that we compare apples with pears and the information that comes out won't support robust decision-making.' She added that the Derby system had made some progress with capital following a need to create regional capital envelopes.

As provider of the Integrated Single Financial Environment (ISFE), NHS SBS has a good view of consolidation challenges, delivering a single financial platform for commissioners in England. 'The ability for NHS England and NHS Improvement to report on every single CCG today, and in future every ICS, at the push of a button is one of the key benefits for ISFE,' said SBS's Mr Sutcliffe. But discussions with providers and systems had reinforced the idea that consolidation across all organisations in a system is a key concern.

Mr Sutcliffe believes technology could provide the solution. 'Looking at technology into the future, it is moving really quickly and can enable consolidation in a different way without needing organisations to be on the same finance platform,' he said. He added that NHS SBS was looking at various solutions.

HFMA ROUND TABLE

In conclusion the roundtable highlighted the importance of clarity. Language and easy to understand tables and graphics were essential. Reports needed to get the right balance between giving only the essential information to provide boards with the assurance that objectives were being met and risks managed, while providing enough detail to enable proper understanding and challenge. And context is crucial – not just presenting the number, but explaining why it is important and the implications of movements.

New ways of presenting data and changes over time – such as statistical process control – provided opportunities to help boards hone in on variations that are outside the normal range and need addressing. However, the move to system working will place new demands on financial reports to boards, presenting technical challenges such as meaningful consolidation, and a new focus on pathway costs and health inequalities.

PHM: next steps

Despite the major focus on Covid-19 over the past 18 months, some health economies have continued to make progress with the development of proactive models of care, informed by the analysis of wide-ranging datasets. Steve Brown reports

The *NHS long-term plan* envisages new integrated care systems that move away from the delivery of reactive care towards a more proactive approach. This will see systems focusing on whole populations, not just those who are sick right now, and using population health management (PHM) techniques to deliver better outcomes and address health inequalities, while making the best use of scarce resources.

It is an ambitious aim. But the potential benefits are huge. In principle, the approach will enable systems – working in partnership with bodies outside of health – to address the wider determinants of health and health inequalities. It is estimated that healthcare only accounts for 20% of a person's health outcomes and a much greater impact can be achieved by looking at some of the causes of poor outcomes, such as housing, employment, education and environment. But even just within health, it should mean systems can focus on the best way for health services to anticipate and meet the needs of its communities.

Andi Orlowski, a director at the Health Economics Unit, within the Midlands and Lancashire Commissioning Support Unit, and an adviser on population health for NHS England and NHS Improvement, believes it is right for the NHS to have such a central role.

While it may only be responsible for part of a person's health outcomes, the health service sees the consequences of the failure to intervene sooner or to tackle wider determinants of health.

'Maybe our big role is actually highlighting the poor outcomes that come from this and creating the business case,' he says. However, he suggests it will be important that this central role does not lead to an over-medicalised response – real success will often be actions that avoid healthcare interventions. And he believes longer term financial settlements may be needed to enable the NHS to invest now in interventions that may have a longer term pay back.

Data is the backbone of PHM and, by using historical and current data about people's health and service use, systems are able to design care provision effectively around their own populations, as well as help eliminate health and care inequalities at the source. It typically starts off with segmentation and stratification and makes use of other analysis tools, such as impactability modelling and theographs (*see PHM: a quick guide, right, and Making an impact, page 23*).

Since publication of the *NHS long-term plan*, the NHS has been preoccupied with responding to Covid-19 and maintaining other services as much as possible. However, the pandemic has also increased the focus on health inequalities and many health economies have managed to continue to make progress with PHM ambitions.

NHS England and NHS Improvement run a PHM development programme and to date 39 systems have been involved in three waves.

Phil Walker, deputy director of PHM at NHS England and NHS Improvement, acknowledges that many parts of the country are at different stages, but adds: 'It's incredibly rewarding to see the focus ICSs are placing on putting the building blocks of PHM in place and how this is enabling the design of new proactive integrated care models for at-risk population groups.'

The national bodies plan to look at 'how linked data and predictive population health analytics can drive insight into future use of collective resource and new payment models across place-based partners', he says.

Leeds is arguably one of the more advanced systems in terms of PHM. A city-wide report, *System blueprint for population health management,* was published four years ago. And the clinical commissioning group more recently was one of the first four areas to go through the central PHM development programme.

This year the CCG published a draft of its *Left shift blueprint* setting out the improvement it wants to see for outcomes over the next 10 years

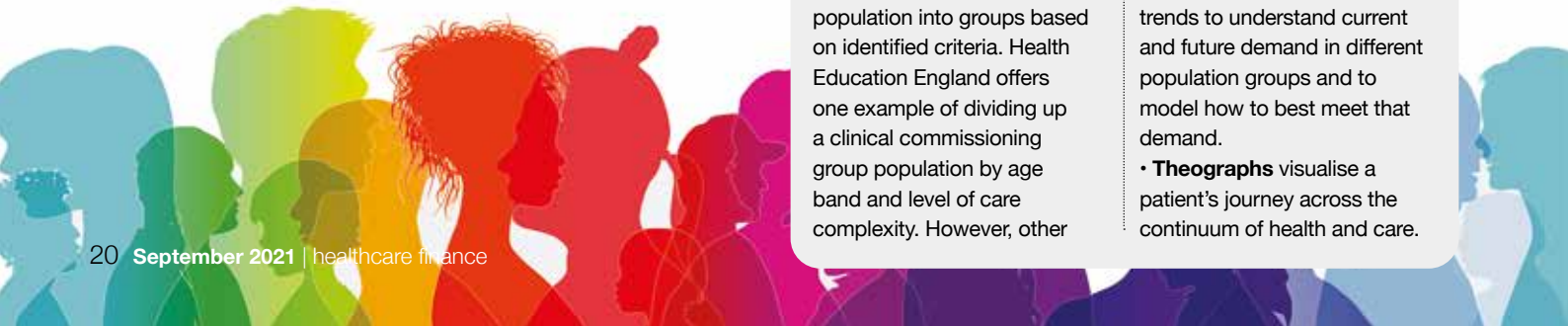
PHM: a quick guide

Population health management has five aims: enhancing experience of care; improving population wellbeing; reducing costs; addressing health inequalities; and increasing workforce wellbeing.

It uses wide-ranging data to target tailored interventions to improve the health of specific populations and cohorts. And it has a particular focus on addressing the wider determinants of health, not just health and care.

A number of tools are used to understand population need and to think about interventions that would improve outcomes for different population cohorts. Health Education England describes these as follows:

- **Segmentation** divides a population into groups based on identified criteria. Health Education England offers one example of dividing up a clinical commissioning group population by age band and level of care complexity. However, other models, such as Bridges for Health and variations on it, break populations down by healthcare needs, with different segments for cohorts such as: healthy; acutely ill; chronic conditions; and frailty.
- **Risk stratification** helps to understand who within each segment has the greatest risk of an adverse health event. Most people are not in the highest risk group and their care may already be optimised. It may be more effective to concentrate on the rising risk population.
- **Impactability** explores how much different cohorts will benefit from a range of interventions.
- **Financial risk (actuarial) modelling** uses data and trends to understand current and future demand in different population groups and to model how to best meet that demand.
- **Theographs** visualise a patient's journey across the continuum of health and care.



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across nine programme areas, from healthy populations to end-of-life care. PHM is identified as the key approach that will be used to address the needs of specific population groups and develop pathways that deliver better outcomes and value.

Jenny Cooke, director of population health planning, joined the CCG at the beginning of the year to take this work forward. 'For Leeds, the journey is about moving away from PHM as "something we do" – a specific project around a specific geography and a specific population – to the way in which the whole system organises itself,' she says.

As part of the earlier development programme, four of the city's 18 local care partnerships (LCPs) were supported to test out the PHM approach and tools in areas related to the city's frail population – a previously identified priority for the city. LCPs are teams of people from general practice primary care networks, the NHS, city council and third sector services working together to improve health and care delivery for their communities.

These four projects provided proof of concept, with the approach of population segmentation, data analysis and impactability modelling leading to pathway revisions for different subsets of the frail population. In one area, the focus was on frail elderly with dementia in care homes, while in another the spotlight was on people with moderate frailty, balance issues, sleep disturbance and nutritional deficits.

Following the pilot programme, the approach was rolled out across all of the city's 18 LCPs and Ms Cooke says there are numerous examples of changes to pathways that have improved outcomes and patient experience. For example, local teams looked at a sub-cohort of people living with frailty, who were predicted to be at most risk of deterioration in health. Dementia, mobility and nutrition were all identified as contributory factors that compounded this risk and an anticipatory care model was introduced to support this group. This involved referrals to 'live well' consultations, and individual medical consultations in clinic and home visits led by an occupational therapist.

Ms Cooke says this programme was a good example of Leeds taking forward targeted work on specific populations. But it was outside of the normal planning process. 'The learning from that phase was that it was very much done as a separate project on top of the day job,' she says.

Population-focused boards

While the sub-population specific approach to PHM is still important, the aim is now to focus more on whole segments of the population, with the ability to drill down where necessary. This will see city-wide population-focused programme boards set up for each of nine programmes identified in the *Leftshift blueprint*. For example, there will be boards for: children; adult mental health; and long-term conditions.

Building on existing groups and structures, these boards will bring together all the partners with an interest in their particular programme area. They will increasingly take on responsibility and accountability for the outcomes of that population. They will scrutinise wide-ranging data relating to their specific populations, monitoring agreed outcomes and able to spot if any LCPs look like they have specific challenges. At this point, neighbourhood teams would get involved, adding their understanding of the causes of any problems and addressing any issues.

This is all happening amid wide-ranging conversations on governance and structural arrangements as part of the move to integrated care boards (ICBs) and integrated care partnerships (ICPs). One of their first moves would be to develop clear outcomes for their specific populations where these do not exist, and understand spending patterns and how these could change to deliver the desired outcomes.

This will increasingly become a very real exercise as from autumn each programme board will be given a budget. Initially this will effectively be an indicative budget, but in future the aim is for it to be a real delegated budget and the programme board will control how it is spent. 'They are the experts for their population, so they should be able to make decisions collectively about the population and how the money is used,' says Ms Cooke. 'That is a real cultural change from the first phase of the PHM work in Leeds. At that stage, there was lots of multidisciplinary design, but the decisions on how to pay for the redesign then went back to the CCG. Under the new approach, there will be a much more joined-up conversation.'

System support

'What do we mean by population health?' asks Tracey Cotterill, software supplier Civica's managing director of population health intelligence (PHI). 'No two integrated care systems would give the same definition.'

Until recently she was a finance director in the NHS, most recently at Great Western Hospitals NHS Foundation Trust, so she is well qualified to give an inside view.

'There is an overarching view of what we mean in principle by it, but different local areas are putting a different perspective on it relative to their local population's needs or where they see the pressures in the system,' she continues. So, while in principle it is about whole populations, for many health systems there is a micro view about 'which cohort should we focus on'.

At the heart of the approach is data and analysis – lots of it. John Doran, the company's head of solutions strategy for the PHI business unit, says the NHS already has rich data at its fingertips. This includes an improving database of patient-level cost information – putting the service well ahead of many other sectors.

However, Ms Cotterill, says this data can be massively enhanced by bringing in feeds from other parts of the public sector. 'I've compiled a list of the types of metrics that an integrated care system might want to measure to see if population health interventions are being successful – and it is a really long list.'

Helping systems to work with these massive data sets – from across the NHS and other public services such as housing, police and social care – is where the company can help, building on its experience with massive patient-level data sets for costing.

The aim is to provide a 'bird's eye to worm's eye' view, says Mr Doran – exploring what is driving resource consumption at broad population level but being able to drill down in to place or even lower.

Ms Cotterill says using artificial intelligence and machine learning tools, the system can provide insights that healthcare practitioners may never have thought to look for. 'With traditional business intelligence tools, you have to ask the right questions to get the right answers, but new systems can provide this demographic insight without being asked,' she says.


Jenny Cooke

This won't happen overnight and there are major hurdles to overcome. Just setting indicative budgets is a pretty tall order when the whole CCG and local providers don't even know their funding for the second half of the year, let alone for future years.

And currently programme budgets will be set on commissioning spend. Ms Cooke acknowledges that the real goal has to be having budgets broken down by the actual costs of delivery at citizen level. This would then enable programme boards to understand the real impact of, for example, taking activity out of the acute sector and meeting the demand in a different way in the community – taking account of a provider's unmovable fixed costs.

But while good patient-level costs exist for acute activity (*see Making it real, Healthcare Finance March 2021*), there is still some way to go before there are comprehensive costs for whole pathways, including community and mental health services and, ideally, social care services.

Simulation test

However, there are plans to test out how the system could work. As part of its ICP development work, Leeds is planning to run a simulation event on frailty. This will effectively test out how a programme board might operate. Using as much real data as possible, the event will throw a number of scenarios and questions at the frailty board. Any lessons coming out of this will inform the establishment of the other boards.

Back in real life, the frailty programme board will have a number of decisions to grapple with too. Several initiatives on frailty – including a virtual frailty ward – have been based on non-recurrent funds and the programme board will take the lead role in thinking through what to do once that funding runs out, as well as deciding how to invest any further funds coming through NHS England.

There is a big agenda ahead, including getting better alignment between the city's eight-part segmentation model and the nine blueprint programmes. Ms Cooke is keen to make rapid progress, but is realistic about what can be achieved given the current workload, which has clearly increased as a result of the Covid-19 pandemic.

There is huge pressure on clinicians as services look to address a major backlog of care, while continuing to deliver Covid care in an environment of continued high infection prevention and control. And many will not be familiar with the concept of a population health approach (although those that have been involved to date are enthusiastic). But Ms Cooke says the recovery programme in some ways offers an opportunity for a new start. In many areas, the aim is to build back better, not simply return to old ways of delivering services. So now could be exactly the right time to make the switch to population health.

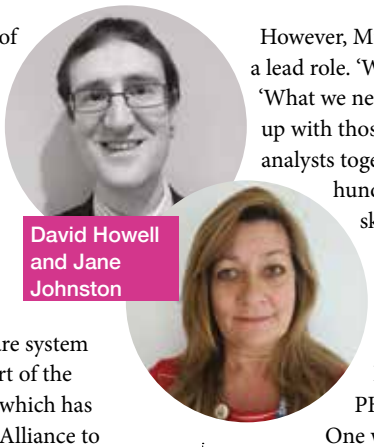
She adds that the vaccination programme – bringing staff and agencies across the city together around a clear outcome, changing approaches for different population groups and monitoring the impact – is a perfect example of population health management in action. It quickly highlights what can be achieved.

While programme boards managing their own budgets in a way that improves the outcomes for their population is a definite goal, she has more modest ambitions for year one. 'Success in year one would be getting a good, shared understanding across all programmes of what is currently being spent and what that delivers, along with the needs and assets of the population, and shared sense of outcomes,' she says. 'Until we really understand this, we shouldn't be making decisions and recommendations – we'd just be making guesses.'

Making an impact

The Surrey Heartlands care system believes using data is the best way to improve its quality – it has put impactability modelling at the heart of its PHM approach

There are two schools of thought on the importance of data quality within population health management (PHM). One group argues that you can't start to base decisions on data until you have access to all the data you need and it is of sufficient quality. The other recognises that improving data quality is an ongoing challenge and the best way to improve the data is to share it and use it.



David Howell and Jane Johnston

David Howell, deputy director of information at Surrey Heartlands Health and Care Partnership, is firmly in the second camp. Not that the integrated care system isn't taking the data quality aspect seriously – it is part of the Thames Valley and Surrey Care Record Partnership, which has signed a contract with System C and Graphnet Care Alliance to provide a region-wide shared record and population health system for 3.8 million people.

It is building its PHM approach on this platform and there is a major focus on getting the right digital infrastructure in place. But it is also keen to make practical progress and ensure that other levers are also in place to support the long-term use of PHM. 'We are also working on ensuring the right people can access this information and that they are trained with the skills and expertise to undertake PHM,' says Mr Howell.

'Up to now, a lot of analytics in the NHS has been around contract management processes, so we are really good at the first step in PHM, which is looking back and asking what went wrong, what worked well and why. But PHM is taking it a step beyond this and understanding where things will go in the future. Once you understand the direction of travel, it is then about using that information to better inform decision-making. That is quite a new skill set for a lot of people.'

This involves a general upskilling of capabilities beyond the use of SQL to pull out data and more use of newer statistical tools such as R and Python. 'These tools support analysts to understand patterns within data in more detail and allow for the onward sharing of more robust and detailed information to clinicians and commissioners,' he says.

However, recognising that PHM cannot be delivered by any single person, the system is also looking to bring together different analytical staff from across its area, including organisations outside of health, to 'join up all the bits of the jigsaw'.

It is frequently cited that only 20% of a person's health outcomes can be attributed to healthcare. Given this, some might question whether PHM should be a health-led initiative.

However, Mr Howell believes that the NHS is well placed to take a lead role. 'We understand the outcomes really well,' he says. 'What we need to get better at understanding is why people end up with those outcomes – and that comes from bringing those analysts together and using those tools that can look at literally hundreds of thousands of biomarkers and get under the skin of the population.'

Surrey Heartlands is part of the second wave of the NHS England and NHS Improvement PHM development programme – although activities have stopped and started during the Covid-19 response. Four of the area's primary care networks took forward PHM projects, each looking at different local priority. One was focused on the health inequalities agenda, looking at a cohort of the population based on frailty, multiple long-term conditions, ethnicity and deprivation.

Ongoing aims

Jane Johnston, the system's head of PHM analytics, says the initial focus was on how changes to direct care could improve outcomes. 'But as we move forward and develop our PHM capability, we will start looking at the secondary uses and that is where we start getting into more strategic areas – if we invest in this area, what will be the impact in another area?'

It is looking to expand its use of impactability modelling – a technique that measures the degree to which sub-populations will benefit from a range of interventions and uses this information to tailor pathway to optimise value.

She highlights an example around falls and how a system might traditionally target a simple overall 10% reduction in falls to save acute treatment costs. This target is then typically cascaded down to primary care networks. However, this takes no account of the different population characteristics that may trigger a fall, but only focuses on acute data and takes no account of future demographic changes.

Instead, the population can be segmented, future population growth and spend can be determined for each cohort at each touch point in health and care, and the segments identified where the greatest pressure is likely to arise. Then artificial intelligence can be used to identify new individuals who may become at risk of falling that meet the criteria of that particular segment. However, Ms Johnson warns that the results need to be considered carefully to ensure that the response is not exacerbating health inequalities.

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HFMA year-end survey: looking backwards to look forward

Technical

Every year, the HFMA runs a year-end survey to see what lessons can be learned to support its own work programme and to provide feedback to the national bodies, *writes Debbie Paterson*. For the first time this year, we also asked auditors for their comments. The full report will be published later in September, but there are two main themes emerging.

The first is that the change in the financial regime had a major impact on the preparation and audit of the accounts.

The second is that the difficulties in the audit market that we highlighted in our briefing – *The NHS external audit market: current issues and possible solutions*, **hfma.to/sep215** – in February remain a problem.

As expected, 2020/21 was a difficult year. In 2019/20, the first lockdown had an impact on the practical arrangements for preparing and auditing the accounts, but had very little effect on the numbers in those accounts.

The whole of the financial regime was completely revised during 2020/21 – not once, but several times – so there were few parts of the accounts that were unaffected.

The role of the national bodies changed as some arrangements, such as the procurement of personal protective equipment (PPE), were centralised. This led to some very specific issues around accounting for centrally procured stock and assets.

If central procurement continues, then the process of agreeing the volume and value of transactions will have to be undertaken on a more frequent basis and cannot be left to the year end.

Block contracts became the order of the day for most of the year. On a positive note, half of those who responded to the survey said that the agreement of balances process was better than previously because of the reduction in transactions.

However, for 12% of those who responded, the process was worse this year than before.

This was mainly due to lack of communication between bodies and difficulties agreeing balances and transactions with NHS England and NHS Improvement. It is clear that the agreement of balances exercise remains a challenging part of the year-end process.

As the financial regime for 2021/22 has not returned to the pre-pandemic normal, there are some lessons that can be learnt.

As noted above, arrangements introduced as emergency measures have become business as usual, so the accounting and reporting arrangements also need to be formalised and not a year-end only exercise.

Transactions between NHS bodies have also changed as a result of the lack of contracts, which means that documentation and assessment of the substance of the transaction become more important. This is likely to continue into 2022 and beyond as system working becomes commonplace.

Another positive from the survey is that the revised guidance, both in the *Group accounting manual* and in guidance to auditors on going concern, was well received.

However, both commissioners and their auditors noted that further guidance will be needed in 2021/22 to reflect the enactment of the *Health and Care Bill*.

Given that 2020/21 was the second year that was audited remotely, some lessons had been

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learnt. But the general consensus is that communication is slower and issues are more difficult to resolve remotely than in person.

One issue that will need to be resolved ahead of 2021/22 year-end is the closedown timetable. NHS bodies are generally in favour of returning to pre-Covid timescales – they see the extension of the timetable as giving auditors more time for additional work as well as taking the attention away from the current financial year.

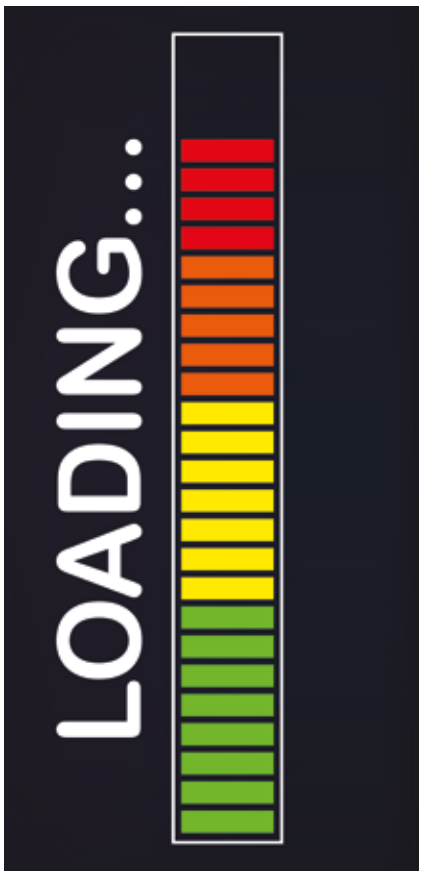
However, auditors are struggling to meet the additional regulatory requirements, while catching up with the delayed audits in other sectors, particularly local government.

This seems to have been made worse by the lack of interim audits in 2020/21 at some NHS bodies, as well as the introduction of the new value-for-money requirements.

At least in 2021/22, the work on value for money can take place earlier in the year, as the guidance is now available.

Each year is different so, no doubt, there will be fresh issues to contend with in 2021/22. But learning some of the lessons from the previous year may make the process a little less difficult.

Debbie Paterson is the HFMA's policy and technical manager



Technical review

Recent technical developments

Technical

Northern Ireland's comptroller and auditor general has highlighted a disagreement with the local Department of Health over the accounting treatment of £135m of spending in the Department's 2020/21 annual report and accounts. Kieran Donnelly said he was concerned about the treatment of spending as **accruals rather than provisions** in three spending areas – the £500 staff recognition payment, a holiday pay accrual and clinical excellence awards liabilities over the last four years, which remain unpaid. Under International Accounting Standards and budgetary guidance from the Department of Finance (DoF), he said all three payments should have been treated as provisions. 'The Department contends that this does not represent an attempt to circumvent DoF budgetary guidance in order to retain funds and I have no evidence this is the case. Nevertheless, the effect is to retain a significant amount of funding, more than £135m, within the [health and social care] sector that would otherwise have been redistributed within the Northern Ireland funding bloc or returned to the Treasury.' He expected to see a payment of these retained funds by 31 March 2022. **hfma.to/sep211**

NHS England and NHS Improvement have issued guidance on corporate governance and financial management standards for **independent sector providers** of NHS services. The document brings together best practice to help providers of commissioner-requested services adopt and apply the financial management and corporate governance standards required by their licence conditions. The guidance covers themes including: appropriate governance structures; decision-making and the use of an appropriate assurance framework; the role of the audit committee; reporting and oversight of financial information; and management of complex contracting forms. **hfma.to/sep212**

Designate chief executives of new integrated care boards must be identified by the end of November, according to interim guidance on the **functions and governance of integrated care boards**, published by NHS England and NHS Improvement. Designate finance directors, medical and nursing directors and other executive roles should be identified by the end of the fourth quarter of the year. The guidance sets out minimum membership requirements for ICB unitary boards, including: a chair and at least two independent non-executives, four executive roles (chief executive and finance, medical and nursing directors) and at least three partner members (typically including an NHS provider chief executive, a representative from a primary medical services provider, and a local authority chief executive). The guidance also covers ICB committees, providers and provider collaboratives, place-based partnerships and the management of conflicts of interest. **hfma.to/sep213**

An HFMA briefing highlights four messages to help finance staff support their organisations in the **transition to new integrated care boards** (ICBs): start now; work together; ensure good housekeeping; and communicate constantly. Multiple clinical commissioning groups will be merged into single integrated care boards on 1 April 2022 and, in a few complex cases, existing CCGs will be split across more than one ICB. *Starting well: ensuring that CCGs leave a good legacy* warns that, while CCGs will be most affected, all organisations will feel an impact, so all affected bodies must work together to the same time frames. The briefing lists the key requirements for finance staff ahead of the reorganisation: understanding all balances on the statement of financial position; resolving disputes where possible and documenting any unresolved issues; deciding who will pay unpaid invoices at the end of the year; and agreeing all balances between bodies joining the ICB. **hfma.to/sep214**

NHS England and NHS Improvement have responded to requests for further clarity on the **treatment of local authority funded services** in the national cost collection (NCC). Typical services include health visitors, school nurses and sexual health services, and current guidance states these should be excluded from the NCC. The national costing bodies have said that, for 2021, organisations should continue with the local process used for the 2019/20 NCC. If organisations included the local authority funded services in 2020, they should do so again in 2021, but exclude them if that is how they treated them in 2020. The inclusion of local authority services is being reviewed for 2022. Further queries should be sent to costing@england.nhs.uk with the subject header 'FAO FB – LA services'. **hfma.to/sep215**

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Review aims to fine-tune HFMA qualifications

By Emily Osgood, HFMA head of education and professional development

Training

More than 600 students have started a qualification with the HFMA Academy since we first launched our advanced diplomas in healthcare business and finance five years ago. For some people, the term 'student' can conjure up images of youngsters or those at college. But many of those studying HFMA qualifications are in fact senior finance and other NHS staff, who have made time to gain extra skills and knowledge to further their careers and enhance their value to the NHS.

This significant cohort of students is spread across both our advanced business and finance diplomas and the diploma in advanced primary care management, which has broad appeal but has been particularly popular with GP practice and commissioning body staff.

We are proud of the qualifications we have developed. The HFMA has a long history in staff development and had already moved into the provision of e-learning short courses. However, the step into masters-level qualifications was a major undertaking.

Our analysis at the time suggested the course met a need for a finance qualification specific to healthcare.

Initially, we saw this as providing opportunities for learning and development beyond finance practitioners' main accountancy qualification. But we quickly realised that the demand for formal masters-level qualifications was much wider. There is both a need and an enthusiasm for these programmes across the NHS in general and clinicians make up more than a quarter of the business and finance students to date.

Feedback and results suggest we have created robust qualifications, with students challenged and impressed by the depth of the content.

The course content is already subject to a thorough and ongoing update process. Things move fast in the NHS and we work hard to keep the contents current. Work is already under way to ensure the qualifications' content reflects the reforms set out in the *Health and Care Bill*, which will see the NHS move to a system-based way of working, and are expected to come into effect from April 2022.

However, five years in, we are now taking the opportunity to review both the qualification programmes. We want to ensure they are delivering the right learning outcomes.

This means primarily meeting the needs of our students, but also checking in with NHS finance directors and senior leaders who may be interested in sponsoring staff members to take on further studies.

We are also keen to explore the benefits of harmonising the intakes for the two qualifications across the year – we currently have six intakes a year across the two programmes and want to understand if these start dates remain the most appropriate for NHS colleagues.

We are undertaking a number of surveys with different stakeholders as part of the review – and if we've contacted you, we'd be grateful if you could spare the time to respond. We'll also be holding a focus group, involving current and past learners, during September.

We recognise that the past year has been difficult for everyone in the NHS, with long hours and intense workloads. For some people, this has not been the right time to take on further studying, and we have seen a number of deferrals during the year.

For others, home working has provided a good context for study, often freeing up hours previously lost to commuting.

However, while the NHS continues to face challenges both in terms of Covid-19 and the recovery programme, hopefully we can all look forward to a bit more stability. We have a new cohort of enthusiastic learners starting this month and will take on board any lessons from the review process once it is concluded to ensure our qualifications continue to meet the demands of users and the NHS.

One NHS Finance launching this month

One NHS Finance

One NHS Finance (ONF) and its three new programmes for Future-Focused Finance, the National Finance Academy and the Finance Innovation Forum are launching this month.

Feedback from the ONF engagement campaign that began at the end of 2020 has been developed into a large offering of training and development opportunities to which everyone working across the finance community will be given access.

A new national finance development strategy that will also be launching in September will underpin the programmes.

The strategy includes six core values that the finance community shaped via their ideas, comments, and feedback during the engagement campaign. The core values are to be:

- Patient-focused
- Inclusive
- Fair
- Collaborative
- Innovative
- Accountable.

ONF will be launched at two virtual events – on the morning and afternoon of 23 September – by Julian Kelly, chief financial officer at NHS England and NHS Improvement, and chair of the Finance Leadership Council. Delegates tuning-in to watch the events can expect to hear from senior leaders who are championing the programmes in their regions, as well as finance staff who are leading and developing some of the programme areas, such as the value maker network, and inclusion and diversity ambassadors. On the day, a new suite of development opportunities for all bands will be made available.

• To view the agendas and book places to attend, visit bit.ly/3Asp0FG

Diary

While events continue to be delivered online, it is hoped that some events later in the year will be in person

September

09 (B) South Central: annual conference
10 (W) Sustainability and savings through the green plan: lessons from Cornwall
14 (I) Introduction to NHS costing
15 (B) Eastern: social value update
15 (B) Kent, Surrey and Sussex: introduction to NHS finance
15 (H) Productivity and efficiency in NHS providers
16 (B) South West: annual conference
20 (B) Northern: introduction to leading change
21 (H) The changing landscape of commissioning
30 (B) Wales: HFMA Cymru/Wales and ACCA Cymru/Wales annual conference

October

06 (I) International value symposium
07 (H) Workplace wellbeing in the NHS
11-13 (B) Kent, Surrey and Sussex: annual conference
13 (B) West Midlands: conference quiz
14 (B) West Midlands: annual conference
19 (H) NHS finance update for chairs, non-executives and lay members
20 (B) Eastern: matrix working
21 (N) Charitable funds
21-22 (B) Yorkshire and Humber: annual conference

November

02 (H) Estates and facilities forum
09 (H) Mental health conference
18 (H) Transformation and collaboration forum
24 (I) Costing revolution summit
24 (B) Eastern: integrated care systems

December

06-10 (N) HFMA annual conference

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

Estates and facilities forum
2 November, online and in person

This hybrid event, taking place online and in person at Rochester Row in London, examines the priorities in NHS estates and facilities, and where finance staff must work with estates colleagues. The event will focus on issues including financing capital development while considering estates planning at system level, and demonstrating value for money and managing the estate to maximise benefits to patients.

Delegates will hear presentations on climate change and the impact of the zero-carbon agenda, developments in procurement, and the latest on the private finance initiative, including handovers and project assurance.

There will be a mix of plenary and workshop sessions. Speakers include Royal Berkshire NHS Foundation Trust chief finance officer Nicky Lloyd (pictured). There will also be several speakers from NHS England and NHS Improvement, including national sustainability and estates and facilities management workforce lead Fiona Daly, as well as Simon Corben, director and head of profession, NHS Estates.
The event is free to HFMA Hub partners, with up to four online and two physical places available.

• For more information on the event, or to register your interest, please email josie.baskerville@hfma.org.uk

HFMA annual conference
6-10 December, online and in London

The association's annual conference returns as a hybrid event this year, with a traditional conference in London complemented by a live stream for those who wish to attend virtually. The first half of the five-day programme will be online, but delegates can attend in London in the latter half of the week. All five days will be streamed.

As always, the event promises a mix of technical, educational and leadership content in workshop and plenary sessions. Speakers will include NHS England and NHS Improvement chief financial officer Julian Kelly, HFMA USA 2021/22 president Tammie Jackson, and Health Foundation director of research and economics Anita Charlesworth.

The conference will include regular features such as the exhibition, the HFMA annual general meeting and the HFMA Awards presentation, as well as ample opportunities to network. Social distancing rules will be observed throughout.

• Online packages and face-to-face tickets are available. For further details, visit hfma.to/e8z or email josie.baskerville@hfma.org.uk

Face-to-face time

Association view from Mark Knight, HFMA chief executive

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

My HFMA

It was a momentous day in July when we could finally get back together in the same room, under strict Covid conditions of course. The reason for the gathering was our annual branches' conference – and we were delighted that 10 of the 13 were represented.

For the association, this planted a small flag in the ground to mark our slow progress out of this pandemic. We are now moving cautiously into our autumn programme. But it won't be until November that we see more face-to-face events and, even then, we will still be broadcasting content via the online conference platform.

Work is well under way for the annual conference in December and bookings for both online and face-to-face content are healthy. The conference this year will be a little different. On Wednesday, we will host our popular fringe session, which will focus on the themes and work we've pursued under Caroline Clarke's two-year leadership of the association. In the evening, we will celebrate our graduates' success. And this will provide an opportunity to thank Caroline for her extended leadership role – all the more remarkable considering the significant workload you have all faced during the past 18 months.

On the Thursday, we will hold our annual general meeting and welcome Owen Harkin (pictured) as the incoming HFMA president. We also have a great day of learning and networking lined up and our conference team is busy putting all that together. And on the Friday, following the annual HFMA Awards and dinner the night before, we will send you home with a veritable feast of professional development.

It's going to be a tremendous event, so don't hesitate to book. And if you can't attend in person, please look into our online package, which allows the whole finance team to get involved. All daytime sessions will be broadcast. In fact, the event actually starts on Monday, with half of the content available exclusively online.

One of the big jobs for our new president will be to spearhead the discussions over the HFMA's future direction and I will naturally be there to assist the board in that task. Quite a lot has changed since our last strategy refresh in 2017 and we need to think about the direction the organisation takes. By the time the next magazine comes to you, we will have taken possession of our new office in Bristol.

HFMA chief executive Mark Knight

The early financial results show we returned a small surplus, subject to audit, for the last financial year – a significant achievement given the disruption caused by Covid. Our conference centre is due to reopen in September and we are building a good pipeline of business.

After a year of adapting and becoming more digitally connected, we have taken time to reflect on how we can move forward and learn from the experiences we've had. As a team, we've been reviewing our work, our approach and our offerings, and are working on a new brand look to take the association into a new era. Members will get a first view of this when we launch, so keep an eye out for changes in November.

So what is the secret of our success? Well, you, of course – our members, without whom we couldn't function in any meaningful way. If you aren't yet involved and would like to be, let me know via **chiefexec@hfma.org.uk** and we'll see what we can do. Have a great autumn!

Member news

The HFMA branches conference in July was the first face-to-face event the association had hosted since March 2020. A total of 20 socially distanced delegates, from 10 branches, attended the event, which was held at Rochester Row in London. The conference included sessions on the new National Finance Academy and the evolving role of the HFMA branch, as well as an update on the association's policy and technical work.

The **Scotland Branch** has a new administrator, Natasha Plant. She can be contacted at natasha.plant@hfma.org.uk

The **Eastern Branch,** as well as the wider HFMA, has thanked Colin Forsyth (pictured) for his longstanding support and wisdom, which has been valued over the years. Mr Forsyth, head of financial services at the Princess Alexandra Hospital NHS Trust, will be retiring on 17 September, only a few months short of completing 40 years of NHS service. Much of that time has been spent in two 'tours of duty' at the Harlow-based hospital from which he now steps down.

The branch said Mr Forsyth had proven himself repeatedly as one of the NHS's best chief accountants, having presided over a period in which the annual reporting cycle has been slashed from months to weeks. Branch members said he had implemented 'more ledger systems than most accountants have had hot dinners'.

Mr Forsyth has been an avid supporter of the association at both branch and national level, having served as a member of the Eastern Branch committee and the National Accounting and Standards committee.

Appointments

Clair Young has moved to The Shrewsbury and Telford Hospital NHS Trust as deputy director of finance – strategy. She was divisional finance manager at University Hospitals Birmingham NHS Foundation Trust.

Ged Murphy has been appointed executive director of finance, planning and estates at East Cheshire NHS Trust. He was previously director of operational finance at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, where he worked for three years, including an eight-month spell as acting chief finance officer. He succeeds **Mark Ogden**, who has retired after six years as the trust's finance director.

Lancashire and South Cumbria NHS Foundation Trust has appointed **Jenny Hannon** (pictured) chief finance officer. Ms Hannon is currently chief finance officer at Liverpool Women's NHS Foundation Trust and is due to join the Lancashire trust in the autumn. She held senior NHS finance positions prior to becoming director of finance of Liverpool Women's in February 2018. **Sam Profitt**, the Lancashire trust's former finance director, has moved to the local integrated care system, becoming director of provider sustainability at Lancashire and South Cumbria Health and Care Partnership.

Northern Care Alliance NHS Group has appointed **Mina Patel** director of finance: diagnostics and pharmacy. Prior to her appointment, she was associate director of finance at Mersey Care NHS Trust, a post she took up in April 2016. Ms Patel has worked in various finance roles in the NHS over the past 16 years and takes a particular interest in raising the profile of equality and inclusion.

Tracey Cotterill (pictured) has joined Civica as its managing director of population health intelligence. She was previously at Great Western Hospitals NHS Foundation Trust, where she initially served as interim director of finance and then took on the interim director of improvement and partnerships post. She has held a number of senior roles in the NHS.

Nikki Brown has been named head of finance at the East of England Provider Collaborative. She joins from Essex Partnership University NHS Foundation Trust, where she has served as the trust's deputy chief finance officer since it was formed in 2017.

Sharon Hassall is now head of financial services at The Christie NHS Foundation Trust, succeeding **Hilary Caldwell**, who has retired. Ms Hassall joined the trust from Manchester University NHS Foundation Trust, where she was also head of financial services.

Gayle Wells (pictured) has moved to strategic head of finance and procurement staff development at Mersey Care NHS Trust. The role has been created in recognition of the importance and value of finance and procurement staff development. It gives Ms Wells the capacity to support and develop staff in the trust, while continuing to serve as Cheshire and Merseyside value maker lead and HFMA North West Branch vice chair. She recently led the Mersey Care finance team through its reaccreditation at Level 3 Towards Excellence and is supporting the next stages of One NHS Finance nationally.

Ridley joins NHSE&I

Peter Ridley (pictured) has been named deputy chief financial officer – operational finance for NHS England and NHS Improvement, taking up the post as a direct replacement for Sandra Easton.

Mr Ridley joins the national bodies from the Royal Free London NHS Foundation Trust, where he has been chief finance and compliance officer since September 2018. He was director of planning at the Royal Free from 2016 to 2018 and prior to this director of finance and informatics at Royal Surrey County Hospital NHS Foundation Trust.

A qualified chartered management accountant, Mr Ridley joined the NHS on the national financial management training scheme. He is a member of the HFMA Environmental Sustainability Special Interest Group, the Finance Innovation Forum and the London Finance Academy board. He is expected to join NHS England and NHS Improvement later this month.

Sandra Easton, who served as deputy chief financial officer – operational finance for almost two years, has joined Johnson & Johnson Medical Devices Companies UK and Ireland as senior finance director.

Southport and Ormskirk Hospital NHS Trust has appointed **John McLuckie** executive director of finance. He joined the NHS as a graduate trainee in 1988 after graduating from Hull University, and in 1991 he became a full member of CIPFA. He has worked across the NHS provider sector, most recently at North West Boroughs Healthcare NHS Foundation Trust, joining in 2004 and becoming chief finance officer in July 2018.

Jon Evans (pictured) has joined the University Hospitals of Northamptonshire NHS Group as group chief finance officer. The organisation, which is made up of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust, was formed on 1 July. Mr Evans previously served as director of finance at Oxford University Hospitals NHS Foundation Trust. He started his NHS career on the national graduate training scheme.

James Spittle will step down as chair of Supply Chain Co-ordination Limited (SCCL, the management function of NHS Supply Chain) at the end of his three-year term on 30 September. **Heather Tierney-Moore**, who is a SCCL non-executive, will become interim chair.

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 managed to convince the board that we needed a single accounting system for all the clinical commissioning groups… A common ledger made much more sense – though hundreds of CCG finance staff might disagree with me"
Paul Taylor

Taylor takes retirement after 35 years' service

On the move

Longstanding NHS finance director and consultant – and HFMA supporter – Paul Taylor has retired after 35 years working in the health service.

Officially, Mr Taylor retired at the end of June. However, he is spending some time in the coming months finishing off consultancy work at Staffordshire and Stoke-on-Trent Integrated Care System, where he is finance director, and for NHS England on the integrated care system development programme.

Mr Taylor has been an avid supporter and one-time chair of his local West Midlands HFMA Branch and worked with the association's national Financial Management and Research Committee.

He was presented with an HFMA award for his outstanding contribution to the association in 2006 and a Lifetime Achievement Award by the branch in 2016.

Mr Taylor co-authored a report, *Home thoughts from abroad*, in 2005, comparing the English payment by results system with models used in other countries.

But his links to the HFMA started even earlier than his own NHS career. His father, Deryck Taylor, was treasurer of the West Midlands Regional Health Authority, and was closely involved with the association in its early days, when it was called The Association of Health Service Treasurers.

'I was desperate not to be an accountant like my dad,' says Mr Taylor. 'I did economics at university, but when I came to the end of my degree, it seemed the obvious career choice, despite my misgivings.'

He didn't join the NHS immediately, though, instead taking a trainee accountant post with Nottinghamshire County Council.

After qualifying, he moved to Coventry City Council, followed by his first health service job – at Dudley District Health Authority – in 1986. Four years later, and with a spell as acting treasurer at Dudley under his belt, he joined the West Midlands Regional Health Authority as its first GP fundholding project manager.

His first substantive finance director post was at Coventry District Health Authority, which he joined in 1992, leaving after eight years to become director of finance and deputy chief executive at Worcestershire Acute Hospitals NHS Trust.

In the early 1980s, although he was working in local government at the time, he took part in the HFMA UK/US exchange programme, travelling to St Louis and Washington with his father.

'My mum didn't want to go, so my dad invited me,' he explains. 'I must have been in my early 20s and I think I thought the flight was free,' he adds with a chuckle.

But once he joined NHS finance, he went on the exchange in his own right in 2007 and 2008, developing a lasting friendship with the Stivers family from near Chicago.

Surprisingly, he was able to indulge one of his passions on that trip to the States – his support for Aston Villa. 'We went into the Nike shop and the new Villa away shirt was hanging up for sale. It hadn't even come out over here.

'Obviously they'd put it out early by mistake. So, we were able to turn up for the first home game of the season wearing shirts that hadn't yet been released.'

But he is quick to point out that HFMA membership is not just a ticket to football terrace one-upmanship. 'The HFMA is a fantastic network for maintaining personal and professional contact with people,' he says.

Since 2003, Mr Taylor has worked as a consultant, which brought him to a range of jobs, including finance director of the NHS Commissioning Board Authority, the precursor of NHS England.

This was one of a number of career highlights for him, and he was closely involved in negotiating the contract for the integrated single financial environment (ISFE), the ledger system for commissioners that is now delivered by NHS Shared Business Services (NHS SBS).

'We managed to convince the board that we needed a single accounting system for all the clinical commissioning groups,' he says.

'It would have been impossible to consolidate each year if we had done what the trusts had done – having their own accounting system for each organisation.

'A common ledger made much more sense – I recognise there are hundreds of CCG finance staff who might disagree with me here!'

A deal was made with NHS SBS quickly, under a framework agreement that was just about to expire in 2012.

Mr Taylor recalls navigating the Department of Health and Cabinet Office approval processes with just two days to spare, and getting final approval via a text.

So, having been both a consultant and a substantive finance director, which role has he found more fulfilling? Office politics and some of the less valuable aspects of the finance director job can be less of a burden for a consultant, he says, but the flipside is that you can feel less like you're part of the team.

However, he adds: 'When working as a consultant, you do the best job you can, partly for professional reasons, but also because you are approaching the role in the same way, irrespective of whether you are a consultant or employed. You also get the opportunity to work with many more people in very many different organisations and health systems.'

Aged 64, retirement now beckons, and Mr Taylor and his wife will spend more time at their new flat in Weymouth and take opportunities to travel abroad.

He has recently discovered walking football, having wrecked his knees in his youth playing a slightly quicker version of the game, and he plans to rekindle his love of drawing and painting, as well as fulfilling his longstanding dream of learning to play the piano.

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- Deputy Finance Director of the Year
- Costing
- Governance
- Havelock Training
- Working with Finance - Clinician of the Year

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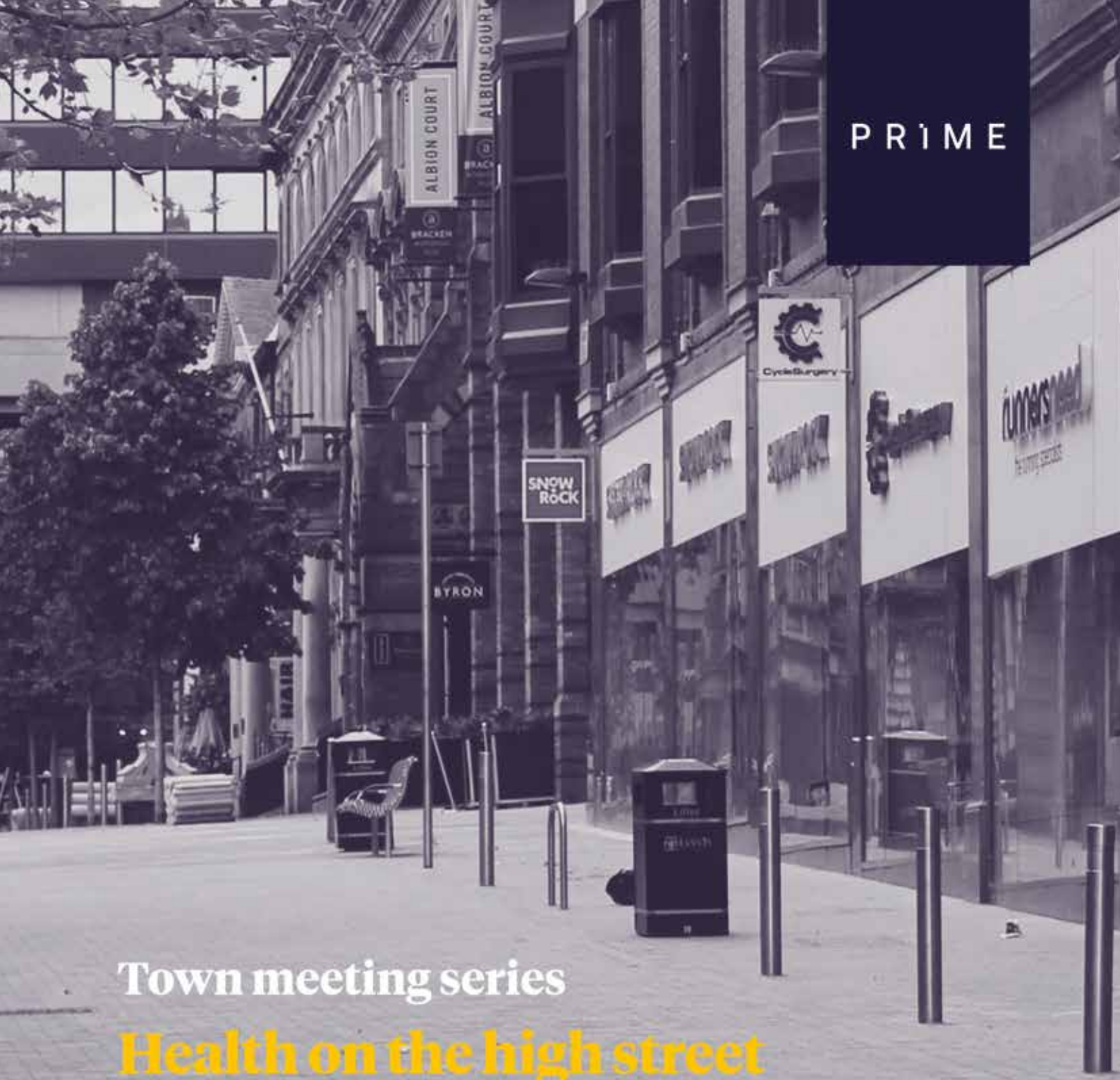

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