healthcare finance

December 2020 | Healthcare Financial Management Association

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The Health Infrastructure Plan

News
Spending review: £3bn welcomed, but will it be enough?

Comment
Vaccine progress offers hope of end to Covid malaise

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

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

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

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

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
Severn Print

HFMA

1 Temple Way,
Bristol BS2 0BU

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

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

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

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

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ISSN 1472-3379

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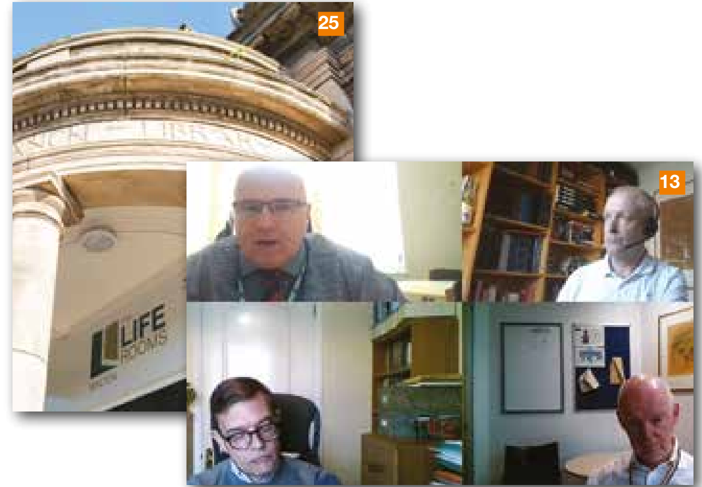

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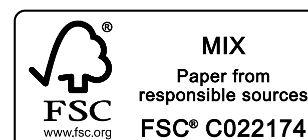

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News

NHS: spending review funding boost may not be enough

By Steve Brown

NHS leaders have welcomed the increased funding included in chancellor Rishi Sunak's spending review, but warned that it would not be enough to meet the challenges facing the service.

November's spending review confirmed a £3bn NHS recovery package as part of £20bn to cover the Department of Health and Social Care's broader Covid-19 costs.

The £3bn breaks down into £1bn to help address the elective backlog, £500m to reduce mental health waiting times and £1.5bn to ease existing Covid-related pressures. The remainder of the £20bn Covid funding will cover Test and Trace costs (£15bn), personal protective equipment (£2bn) and medicines (£163m).

The Department's core revenue budget will increase to £147.1bn – a £6.6bn cash increase on the current year and representing an average 3.5% real-terms increase per year since 2019/20.

The core capital budget has been set at £9.4bn, which is £2.3bn more than pre-Covid times in 2019/20. This includes £4.2bn for NHS operational capital.

Within these departmental figures, the NHS England budget increases by £6.3bn to £136.1bn, with government reaffirming plans to increase the NHS England budget to £148.5bn in 2023/24. With the spending review covering just one year, there is no long-term capital settlement.

However, the government did commit to two multi-year programmes, with £3.7bn over four years to support the building of 40 new hospitals (*The big build, page 17*) and £1.7bn for 70 hospital upgrades. Funding for both will come from core capital funding.

NHS Providers chief executive Chris Hopson welcomed the £3bn of new money, but said it was not clear if it would be enough.

'It's impossible to work out what the total additional funding needs associated with Covid-19 might be for next year,' he said. 'The government should therefore continue to honour its promise to give the NHS whatever it needs to continue to manage the impact of the pandemic.'

NHS Providers was also concerned that the budget for the hospital building programme would not cover all the hospitals announced. And the lack of a multi-year settlement for the broader department meant the NHS still didn't have a fully funded long-term workforce plan.

HFMA director of policy and research Emma Knowles said that access to capital and approval of capital schemes was high on finance managers' agenda. 'The national hospital building programme and improvement scheme are welcome, but the detail of how other capital schemes, which are equally vital in their local areas, can be progressed on a timely basis is not yet clear,' she said.

NHS Confederation chief executive Danny Mortimer described the settlement as a 'Polyfilla budget', leaving major cracks unfilled. He said that while the £3bn was good news, it fell far short of the £10bn estimated as necessary by the Health Foundation.

'Political leaders will need to manage public expectations, as there is a very real risk to the quality of services that hardworking health and care staff are able to deliver,' he said.

NHS England chief executive Simon Stevens said that NHS England had not been looking to reopen the multi-year revenue funding deal, but the pandemic had introduced new costs tied to Covid care. 'We have had financial support for that through the course of this year and our agreement with government is that we will continue to do so going into next year.

'Early in the new year, we will take stock of what the costs are likely to be. In the meantime, systems and trusts should continue to plan on the basis that they will sustain the capacity and staffing that they have available to them now.'

The chancellor highlighted a growing gap between public and private sector wages. In the private sector, wages had fallen by nearly 1% in the six months to September and it had also seen job losses, wage cuts and furlough. 'In such a difficult context… I cannot justify a significant, across-the-board pay increase for all public sector workers,' he said.

But NHS staff were not included in the pay freeze and there will also be a £250 increase for the lowest paid in the public sector. For the NHS, Mr Sunak said he would take advice from the pay review bodies, which will report next spring.

The NHS Confederation said it would be important to see the detail of how trusts will be expected to fund any pay rise. Mr Mortimer added that the £260m for Health Education England to support training and retention was 'significantly below what is needed to address the longstanding workforce shortages'.

And according to Royal College of Nursing chief executive Donna Kinnair, the chancellor had 'failed to act' by not delivering an early and significant pay rise for nurses.

'The level of pay rise that government agrees must reflect the true skills and value of nursing,' she said. 'For now, they continue to be worse off than 10 years ago.' She added that those working in social care and the community also deserved an increase.

John Appleby, chief economist at the Nuffield Trust, underlined this point. 'While promised increases in NHS pay are welcome, without a similar commitment for social care there is a real risk the vulnerable sector will see its much-needed workforce go elsewhere,' he said.

Virtual reality

This year's HFMA annual conference is an online event over two weeks, providing a 12-day festival of learning. Week one features online learning labs and concludes with a one-day student conference. The second week includes keynote addresses that explore HFMA president Caroline Clarke's theme of *Taking pride in our future*. Delegates will receive daily email updates, or see news at **www.hfma.org.uk/news/**

Covid offers chance for reset, says HFMA

By Seamus Ward

The HFMA has recommended changes that could be made to the financial regime to support the post-Covid NHS.

The association said the Covid pandemic offered the chance to reset how the NHS operates, as it has changed significantly how services are delivered to patients.

The financial regime has also changed, with simplified payment mechanisms based on block contracts, ensuring finance does not act as a barrier to patient care. The temporary regime has removed many of the financial obstacles to collaboration and innovation, allowing providers and commissioners to develop new care pathways quickly.

An HFMA briefing, which builds on an earlier discussion paper, says the NHS and the finance profession must not allow the finance system to regress to the previous regime without considering how beneficial changes made during the pandemic can be adopted permanently.

According to the briefing, systems will be at different levels of maturity and this must be taken into account when designing new ways of financial control. Any new financial regime must be based on transparency and understanding the financial allocations to each integrated care system. National contract models should be based on aligned incentives contracts, which may be compatible with the proposed approach on blended payments, as long as there is local discretion over the variable element of any payment.

System ownership of finite resources should be encouraged through the new regime, while each system should have an officer charged with providing healthcare within the financial envelope – similar to a local authority's section 151 obligation to manage financial affairs effectively.

A detailed national tariff will no longer be required to support payments, but a mechanism for reimbursing out-of-area care and specialist treatments, as well as private and charity providers, will be needed. A streamlined tariff should be used to support payments between systems and spot purchases, the briefing says. And the processes around payment of low-value non-contract activity should be reviewed with the intention of adjusting host organisations' allocations rather than payment following the issue of multiple invoices (*see page 39*).

Current costing requirements should also be reviewed. While robust costing information is vital, costing standards must be proportionate, achievable, and deliver easy to understand, high-quality comparable data that is useful locally and nationally. The briefing adds that the current arrangements do not meet these principles. It also calls for a review of cost data collections.

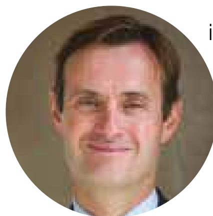
The HFMA backs changes in financial governance and in the capital regime, with transparent, multi-year capital allocations published several years ahead. Capital approval processes should remain streamlined, as they have been during the pandemic.

HFMA director of policy and research Emma Knowles (pictured) said: 'The Covid pandemic has been tough on the NHS, but there are positives to be taken from it, from collaboration and system working, to simplified financial and contracting arrangements.

'Doing things differently during the pandemic has been made easier by the relaxation of financial constraints, which we recognise is not sustainable. But we need to take this opportunity to build on what has worked and remove things that will not support the collaborative model to which we aspire. And we need to it quickly.

'We look forward to supporting NHS England and NHS Improvement in delivering this.'

Covid spending consistent in first six months



NHS chief financial officer Julian Kelly (pictured) said that after reviewing early data returns, he felt 'comfortable' with the financial envelopes set for systems in England.

From October, system-wide financial envelopes were set. These replaced the 'retrospective claims process' of the first half of the financial year, when there were three core elements of provider funding – a block payment based on 2019/20 clinical commissioning group income; a prospective top-up based on the 2019/20 run rate; and a retrospective top-up to fund Covid-19 costs and other reasonable expenditure. CCG allocations were also adjusted to reflect this interim regime.

Publishing month 6 results at the NHS England and NHS Improvement board meeting on 26 November, he said that, broadly speaking, the aggregate level of spending was 'remarkably consistent' over the first half of the year.

The NHS had incurred additional Covid costs of £8bn, resulting in a net extra spend of £7.7bn against the pre-Covid budget. The added spending is driven by top-ups to providers and CCGs. The impact of Covid on the provider sector totalled £4.3bn at month 6, including £1.44bn of lost income, almost £1.34bn in additional pay, and £1.5bn of other Covid costs, offset by spending reductions of around £1bn.

CCGs overspent against plan by almost £2.3bn, with £1.6bn directly related to extra Covid costs. Overall, commissioners overspent by £7.5bn, £3.7bn of which was due to Covid.

'In September the Covid costs continued to come down, but the marginal costs, particularly of the extra activity in the acute sector, were ramping up,' said Mr Kelly. 'For the second half of the year, we have given the NHS financial envelopes to live within. That put more money in to reflect the fact that we were asking for acute activity to continue to step back up.

'With the planning returns we've had back, and with October's data, I still feel comfortable the envelopes are sufficient to allow the recovery of activity, even with, as we have seen in October, the first signs of the second wave we definitely lived through in November.'

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Plans remain in place for training tariff reform

By Steve Brown

The NHS has long wanted to change the mechanism for funding education and training, ensuring healthcare providers are paid the right amount for clinical placements to develop the workforce of the future. It is a slow process, but Health Education England remains committed to delivering a more sophisticated approach that fairly rewards training providers and improves the sector's understanding of what to deliver.

Prior to 2013, funding for NHS providers to cover the costs of training was based on historical self-declared costs, with support ranging from £10,000 to £90,000 for an undergraduate doctor's placement. A new tariff system aimed to put funding on a more equitable basis and provide a mechanism for allowing funding to follow students.

This was important as research in 2013 showed that 48% of UK trained doctors undertook specialty training in the same region as their medical school, leaving some parts of the country with greater problems filling positions. (This is now being addressed by prioritising under-doctored areas as part of the expansion of medical school places by 1,500.)

There are currently three core tariffs covering non-medical placements (nurses, midwives and allied health professions), medical undergraduate placements and medical postgraduate training. The non-medical and undergraduate placements attract a straightforward placement fee, while postgraduate training is a mix of placement fee and salary support.

The tariff system was suspended for the first four months of the financial year in response to the Covid outbreak. Block contracts based on one-third of last year's payments mirrored the simplified arrangements for service funding.

However, plans remain to expand the currencies used within this payment system. A consultation paper in 2018 proposed a currency based on new education resource groups. Under the proposals, the non-salaried placements (non-medical and undergraduate medical) would be broken into 48 groupings, one for each profession. This would include separate ERGs for undergraduate medical, adult nursing, learning disability nursing, midwifery, paramedics, physiotherapy and dietetics, for example.

For postgraduate medical and dental trainees, 81 groupings would have been adopted, with a further 48 used for other salaried professions.

SHUTTERSTOCK

'The response to the consultation was that the approach for the salaried medical and dental trainees may have been overly complex. That's something we will review,' says Jennifer Field (inset), HEE deputy director for finance strategy.

Plans to launch the new currency (as a precursor to attaching prices) in 2019/20 were put on hold. This was to allow progress with connected workstreams, setting up a student data collection and introducing a standardised education and training contract, which will be used in all contracts from April next year.

As part of the data collection, higher education institutes submit their total number of students and placement plans, which is then quality assured by the placement provider.

'We are getting better data,' says Ms Field. 'One of the issues we had with costing education was that providers didn't always know how many students they had on placement with them. This gives them that information. And this will feed into the contract schedules.'

Better data will support improved commissioning of training and inform the service's response to the *NHS people plan*.

But Covid has also further delayed currency development. The focus for HEE this year has been supporting financial stability – hence the block contracts. And while student placements stopped during the first wave, HEE also facilitated early moves for those close to finishing their studies into paid roles supporting the response. As part of the second wave, the aim is to keep placements running – missing two to three months of placements is a major hole in trainees' experience. However, decisions are being informed by local context and pressures.

The plan remains to attach prices to new currencies once they are adopted. There have been a number of education and training cost returns to support the setting of tariff prices. The last exercise covered the 2016/17 financial year, since when education costing submissions have been stood down to enable costing practitioners to focus on patient-level costing.

That exercise implied an underfunding of placements of around £700m, although it was not across the board. In fact, undergraduate medical training was over-funded compared with reported costs.

This has not led to a rebalancing of funding from service tariffs to education tariffs – difficult at the best of times, but particularly when many providers are running deficits. And there are concerns about the accuracy of the data, with a lot of subjectivity involved in the costing of training. For example, providers have to estimate how to split the time spent by postgraduate trainees between service duties and training.

But the data provides relativities between the costs of different training activities. HEE has already used this information. Undergraduate medical placements received no inflationary increase in 2020/21, with HEE's growth used to boost non-medical placement tariffs by £458 and medical postgraduate by £285.

HEE, which is now leading the way in tariff development, on top of its existing role to produce a currency, is keen to make further progress in the short to medium term.

'Towards April 2022, I would hope we would be seeing changes,' says Ms Field. 'It may still be a simplified tariff – we need to let the work play out – but there will be a stepping stone that moves us from the three tariffs to a tariff based on the full new currency.'

Transition from the 2013 changes, cushioning providers from rapid swings in training income, is now nearly complete, with 99% of providers within £1m of their target income under the three tariffs and just £6.3m now needing to be redistributed.

Further changes to tariffs may need another transition. But a more granular funding system, which enables funds to follow trainees and more closely reflects providers' training-related costs, is getting closer.

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News review

Seamus Ward looks at recent developments in healthcare finance

While there has been positive Covid-19 news, with vaccines emerging, immediate prospects look gloomy. Large-scale vaccination will not happen until the new year, so the NHS faces a winter with the normal pressures, plus Covid cases and a large backlog of patients.

We know more than four million patients are on waiting lists for elective care in England, with nearly 140,000 waiting for more than 52 weeks. Around 46% of all the patients had been waiting for more than the 18-week target. The NHS is doing its best to tackle this, increasing services in line with the recovery plan set out by NHS England and NHS Improvement. However, this will be made more difficult if there is a continuing surge of Covid-related admissions.

As US politician Donald Rumsfeld said, there are known knowns and known unknowns. He was widely ridiculed, but the statement could be applied to NHS waiting times. The service knows it has a backlog of patients, as laid out in waiting times figures. And it suspects there is a hidden backlog (a known unknown) due to Covid. The Health Foundation has tried to put a figure on the hidden patients, suggesting it could more than double the number on the waiting list. The foundation said 4.7 million fewer people were referred for routine hospital care between January and August this year. The NHS and government must plan to tackle both the hidden backlog and the known waiting list, the Health Foundation said. NHS England has invited independent sector providers to bid to join a waiting list framework agreement worth £10bn over four years.

Funding is critical to the response to Covid, winter pressures and the backlog. Ministers in Northern Ireland announced that health and personal social services would receive more than £500m in additional funding this year to bolster the response to Covid-19. As well as almost £527m in resource spending, the Department of Health will also receive an additional £32m in capital funding for Covid-related costs. Finance minister Conor Murphy said the health funds would help the response to the public health emergency, including enhancing test, trace and isolate systems. Trusts have been instructed to provide free car parking for staff until the end of the financial year.

SHUTTERSTOCK

Much of the public spending on Covid has been used to procure personal protective equipment (PPE), but the National Audit Office found issues with PPE procurement in the early months of the pandemic. While an NAO report recognised the exceptional circumstances in the period up to 31 July, it said standards of transparency and documentation were not met consistently at government level. However, the auditors did not find any wrongdoing by ministers.

The NAO said standards of transparency and documentation in the procurement of PPE had not been met consistently

A huge IT deal could be on the horizon for the NHS in England, which is examining the feasibility of giving more than 450 organisations an integrated HR and finance system. Companies have been invited to take part in a survey on the viability of providing an enterprise resource planning (ERP) solution for the NHS in England. The ERP would combine the electronic staff record and finance systems, providing a replacement for the integrated single finance environment used by commissioners. The integrated system would be complex and potentially expensive too, and the study is expected to report on recommendations for next steps in January.

However, the Department of Health and Social Care and the NHS received a warning on IT projects in general. The Commons Public Accounts Committee said the health bodies have not learnt from almost two decades of failed IT programmes, including the paperless NHS, which was delayed and 'watered down', and the 'expensive and largely unsuccessful' national IT programme between 2002 and 2011. The Department and the NHS had none of the components needed to deliver their digital ambitions – effective governance, realistic and detailed plans, sufficient investment both nationally and locally, and clear accountability.

Welsh health and social services minister Vaughan Gething outlined a programme of financial support for Betsi Cadwaladr University Health Board, which has now been removed from special measures. Mr Gething told the Senedd it had made some improvements. The support package will operate over three years from 2021/22. It includes: up to £40m a year to cover the board's deficit; £30m a year to improve unscheduled care and build a sustainable planned care programme; and £12m a year to support mental health and to increase capability and capacity.

The Scottish Budget will be held on 28 January, the Holyrood government announced. It took the decision after UK chancellor Rishi Sunak postponed his Budget until the new year. Scotland's finance secretary Kate Forbes said this would allow time to digest the effect of the one-year spending review, take stock of the Covid situation, and the outcome of negotiations on a trade deal with the European Union. However, the Scottish Ambulance Services has been allocated an additional £11m to improve its capacity and resilience over the winter.

Comment

December 2020

Moving beyond the ennui

There may be a general malaise around Covid, but there is blue sky on the horizon

Hi everyone. As we head to the end of a national lockdown, with increasing talk of vaccines and a spending review thrown in for good measure, it's been hard to decide what to write about. I'm spoilt for choice.

The spending review delivered the extra £3bn for the NHS that had been trailed in advance. While the day itself was all about the headlines – the recovery package, capital funding (including four years of money specifically for the hospital building programme), NHS-specific pay rises and Covid funding – the real story will as ever be in the detail.

Recovering from a pandemic is going to take years and we are going to have to put aside important pieces of work to recover. So the settlement needs to come with a recognition of what can realistically be achieved in the course of a year and an understanding of the higher costs of running normal services in parallel with Covid care.

And within the capital settlement, it will be important that there is enough funding to support investment in the NHS digital infrastructure, so we can get to a place that compares with other developed countries and industries.

2020 accelerated our use of remote technology and a virtual world in an unpredicted leap, and we really need to build on this.

We face major challenges ahead and what is obvious to me is how tired everyone is. My clinical colleagues are maxed out, human resources and finance are stretched like rubber bands, and the digital team have disappeared

HFMA president Caroline Clarke

Uncertain times

More detail is needed to understand the spending review's headline figures

Spending reviews are about headlines and setting envelopes. The devil is always in the detail. But that is arguably even more the case for November's one-year review, coming as it did part way through the current Covid-19 pandemic and with the country facing a second wave of the virus.

Everyone has been quick to welcome the extra £3bn for the NHS to meet Covid-related pressures and start to make an impression on the growing waiting list and waiting times. However, they are also quick to underline the huge uncertainty facing the NHS currently.

There was already a gap between funding and demand – amply demonstrated by the continuing deficits in many provider organisations heading into this difficult year.

But we simply don't know how the pandemic will pan out. How long will it continue its grip on the country? What will it cost to run Covid and non-Covid services in parallel? How long will the recovery take and what will catching up cost?

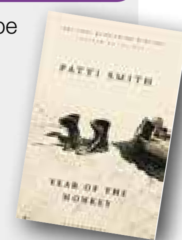
We just don't know the answers to these questions. Recovery will certainly take more than a year – but whether the extra £3bn is enough to meet the costs of recovery that

arise in 2021/22 is not clear. It seems unlikely – although recovery will be as much about capacity as it is about money.

Staff numbers in particular are a major concern. The NHS entered the pandemic

Healthcare Finance editor Steve Brown

PRESIDENT'S PLAYLIST



BOOK I've just read *Year of the monkey* by Patti Smith. I don't know how to describe it – an ethereal journey through the southern US states as she comes to terms with the loss of a friend and her ageing. I can also recommend *Health is made at home* by Nigel Crisp, ex-NHS chief executive. It reminds us that health and wellbeing are our responsibility, with tons of inspiring examples of what we can do post-Covid to improve the nation's health.

MUSIC We've been dancing round the kitchen to Marvin Gaye and Prince. And the last thing I Shazamed was Ghost Poet – *Offpeak dreams*. Love that, love him.

"A huge shout-out for the HFMA crew who have made the conference happen, and let's *Take pride in our future*"

under a gargantuan pile of remote working requests. Even my sunny optimism is being tested.

(And if you're really interested in what's going on in hospitals, watch the documentary series *Hospital* on BBC2, which shows what the Royal Free has been doing over recent months to get restarted and rebuild services. It's been a strange experience having cameras in, but I hope the tale we tell resonates with colleagues round the country.)

I think there might be a general malaise around Covid – when will it really end; I'm over it; I want to see my family; I want to go to the pub etc. If you've read *The Plague* by Albert Camus, it's all familiar. The French have a great word – ennui. Literally, it describes a feeling of listlessness and dissatisfaction arising from a lack of occupation or excitement. So that might not apply to work life, which is as crazy as it's ever been. But all the conversations I have about wider life point to a more general ennui.

But.... there is blue sky on the horizon. We are rolling out fast testing for our staff. Brilliant! It will make such a difference to how we staff and deliver care in all care settings.

And the potential vaccines are looking good, with roll-out plans being hatched as I write. The independent scientific assurance is being gathered, and the Medicines and Healthcare products Regulatory Agency (MHRA) is working its socks off.

If it all goes according to plan, we must get in the queue with our sleeves rolled up. It's the only way we're going to get the economy back on the road.

In the meantime, break your ennui by coming to our conference, which started on 30 November. It's going to be the biggest and the best ever, allowing you to take stock of how weird 2020 has been, and how we can gather energy to focus on the future.

Of course it's virtual – but we have four times the number of registered delegates because of that, and an array of speakers who we just wouldn't be able to cram in if we were meeting in person. So a huge shout out for the HFMA crew who have made this happen, and let's *Take pride in our future.*

Contact the president on president@hfma.org.uk

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carrying around 40,000 nursing and 9,000 medical vacancies. The crisis may have generated more interest in pursuing a future career in health among the wider population. But right now, the service continues to have to cope with virus-related staff absences on top of those existing vacancies.

The availability of staff rather than the money to pay for them may be the biggest brake on progress – although there is also uncertainty over the cost of next year's pay bill. A pay rise for hardworking and tired staff may be richly deserved, but it is not clear how this will be funded once the pay review bodies have given the chancellor their advice.

There is also uncertainty around the capital programme. The £9.4bn capital departmental expenditure limit is a leap forward from the pre-Covid levels of funding. It is good to see the multi-year programmes to build new hospitals and upgrade existing ones backed by formal Treasury numbers.

But beyond this, the NHS only has one year of operational capital on which to base its plans, despite there being wide-ranging capital requirements to address outside of the national building programme.

A full long-term capital settlement is still very much needed.

And there are concerns about whether the level of funding earmarked for the Health Infrastructure Plan will be sufficient to cover all the hospitals due to be built. (We talk to some of the trusts in the first wave of the HIP in *The big build* on page 17).

"The availability of staff rather than the money to pay for them may be the biggest brake on progress"

It is impossible to look at the NHS settlement without looking at the wider context. Chancellor Rishi Sunak quipped that 'our health emergency is not yet over, and our economic emergency has only just begun'. The economy is due to contract by 11.3% this year and output is not expected to return to pre-crisis levels until the fourth quarter of 2022. The UK is forecast to borrow £394m this year, equivalent to 19% of GDP, with the underlying debt at scary levels.

In that context, the health settlement may look more understandable. However, given the direct links between economic hardship and health service demand, the funding might need to be revisited sooner than is currently planned.

In conversation with: Professor Andy Hardy

Andy Hardy, CIPFA President and CEO of UHCW NHS Trust

CIPFA's new president and CEO of University Hospitals Coventry and Warwickshire (UHCW) assesses the impact of COVID and the continuing importance of lifelong learning.

Sarah Shreeves, CIPFA Head of Training, in conversation with Professor Andy Hardy.

Starting as a trainee accountant in the NHS, Andy progressed via roles in different parts of the NHS to become CFO of UHCW in 2004. After four years he became the deputy chief executive, before being appointed chief executive two years later. He is also the senior responsible officer for the Coventry and Warwickshire STP/ICS. Andy has been a CIPFA member since 1994.

Sarah: What have been the greatest challenges you've faced in your career and within the public finance sector as a whole?

Andy: It's difficult to think of anything before COVID! Without a doubt, it has been the biggest challenge. In some ways, it's one of my most fulfilling periods, and that often comes out of challenge.

As public sector finance professionals, we've been through incredibly tough times following the 2008 financial crisis. Whilst many in the public sector will look at the health sector with some envy as we were partially protected, austerity led to the need to make some tough decisions. There are lots of services we used to provide that we don't anymore. We want to provide the best for the populations we serve, and when you stop doing things, irrespective of what that decision is based on, it will hit someone who sees value in it.

Going forward, I think the government will want to invest in the public sector off the back of COVID, having seen the value of what it does as far as managing a crisis is concerned.

S: There are certainly going to have to be some difficult decisions to make about spending. What are your thoughts on the potential impacts of cuts to training budgets?

A: If anything, the COVID-19 pandemic has highlighted the importance of lifelong learning so that you're prepared for when change comes. What I've strongly observed during the pandemic is that those organisations and teams that succeeded were those who were able to learn and adapt quickly.

Lifelong learning plays into how you prepare for unprecedented situations. It's how you can be ready for change and keep on top of what's happening in the world around you. You don't become a qualified accountant and then stop there. You need to be looking at how you learn and develop, including softer skills such as leadership as well as financial skills. When you get into a crisis, you need to be able to adapt quickly. That is about learning both independently and from others.

S: So true. And, in your opinion, what are the skills that NHS finance professionals will need for the years ahead?

A: Well, I think that all finance professionals, whether they're working in the NHS or elsewhere, should continuously consider what stakeholders need from them, how this will impact on their job roles and therefore what skills they need to adopt or improve in order to 'future-proof' their organisation.

Central to that has to be the ability to gather and analyse data and turn it into information that informs business decisions. We are in a world that's awash with data, but we have to make it meaningful. We must be a lot more data aware – and digitally aware.

A few months ago, most people working in NHS finance would never have thought they could do most of their job from home. What does the new normal mean? Future professionals will absolutely have to go beyond the traditional skills of accountancy.

S: Is it difficult for NHS accountants to decide on CPD options that are right for them and their organisation? If recent times have taught us anything, it's that things change fast!

A: Yes, choosing appropriate CPD can be challenging, particularly when we don't know exactly what the future will look like and given that, more than ever, we need to ensure a good return on CPD investment. But what has happened this year won't be the last black swan event we face, and finance professionals in the NHS will need to be resilient to future disruption and change. Helping public finance professionals prepare for the future is core to CIPFA's mission and why I'm so proud to be President.

CIPFA has recently published 'Key Competencies for Public Sector Finance Professionals' which brings together the skills and knowledge required for a robust, resilient and ethical public finance profession, both now and in the future. While not everyone will require every competency in their career journey, it provides a valuable conversation starter. It is designed to help identify where an individual or a team's training needs may lie – whether that's technical accounting proficiency, increasing public value or leadership, influencing and negotiating.

To learn more visit cipfa.org/keycompetencies call 020 7543 5600

CIPFA

Changing paths

Covid-19 has altered how many NHS services are delivered. A recent HFMA virtual roundtable discussed these new pathways, including how the service had introduced, virtually overnight, models proposed for years. Seamus Ward reports

Over the past nine months, the NHS has got used to a lot of change as Covid-19 has swept across the UK. A&E attendances dropped as patients decided against risking exposure, while outpatient and GP appointments moved to phone or video calls to protect patients and staff. Specialist services such as dialysis are increasingly provided in patients' home.

Covid has changed virtually every pathway, but with rising hope of a post-pandemic world, what now? Should the NHS retain and expand on these emerging pathways and how does it ensure the new models meet patients' needs and are cost-effective? These questions were examined in a recent HFMA Healthcare Costing for Value Institute virtual roundtable, sponsored by Baxter Healthcare Limited.

Chair John Graham, director of finance at Stockport NHS Foundation Trust, asked the roundtable about the impact of Covid on patient pathways. Participants agreed it had accelerated pathway changes, many of which the NHS had wanted to introduce for years, such as the move to digital outpatient appointments or shared patient records.

Nigel Foster, director of finance at Frimley Health NHS Foundation Trust, said: 'Many of the things that were changed we were probably already planning to do, but Covid has caused us to move much faster.'

The redesign of the trust's frailty service was one example, with the hospital consultants now working more as part of multidisciplinary community teams. 'The label of the provider really wasn't mattering in the way it used to. People were just working together in a community setting to support frail patients who, by and large, don't need to be in a hospital. You need to provide holistic care rather than siloed specialty care for them. Covid just reinforced that journey we were on,' he said.

There was a potential sting in the tail for acute trusts – reducing lower priority or unnecessary activity meant that in some areas it was hard to achieve last year's activity levels, on which service recovery targets are based.

Claire Wilson, chief finance officer at Wirral University Teaching Hospital NHS Foundation Trust, said the trust had moved much of its outpatient activity from face-to-face to virtual appointments. The trust had been trying for two years to develop its virtual outpatients programme, but progress was difficult until the pandemic. Over two weeks, more than 89% of its outpatient activity moved online, though she said clinical colleagues do not believe it is a full solution. Further work is needed to ensure that it is as efficient as possible.

'It's absolutely the right thing to do at the moment for patients who do not need to come into hospital,' said Ms Wilson.

'We need to do the benefits realisation work and ensure that savings are cash-releasing. The efficiencies are not generated automatically – clinical time for clinics is similar to before, but the savings are in areas such as medical records and estates, both of which need focused change programmes to release the savings.

'My feeling as a non-clinician is that there has been a fundamental shift in terms of virtual working, although it doesn't necessarily mean we won't bounce back to seeing people face-to-face.'

Covid has affected all care sectors. Rachna Chowla, GP in Southwark and joint director of clinical strategy, King's Health Partners in London, said ensuring care was available for all patients while meeting Covid restrictions during the first wave, has led to the current hybrid version of primary care.

In March/April, Covid led to the complete

Participants

- **Rachna Chowla,** King's Health Partners
- **Ann Cole,** Baxter
- **John Connolly,** Royal Free London NHS FT
- **Alice Forkgen,** North West Boroughs Healthcare NHS FT
- **Nigel Foster,** Frimley Health NHS FT
- **Chair: John Graham,** Stockport NHS FT
- **Craig Mustoe,** Baxter
- **Michelle Pilling,** East Lancashire Clinical Commissioning Group
- **Sam Wilde,** Lincolnshire Community Health Services NHS Trust
- **Claire Wilson,** Wirral University Teaching Hospital NHS FT
- **Keith Wood,** Suffolk and North East Essex ICS

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reconfiguration of primary care from face-to-face consulting to mostly video or phone. And in some areas practices were zoned into 'hot' areas (for patients with suspected Covid) and 'cold' areas to look after, and protect, everyone else. In some localities, this translated to system level, with separate hot and cold clinics to serve their populations safely.

The move to remote consulting happened almost overnight. GPs were acutely aware they had to maintain high-quality care, but via remote consulting. GPs also knew they had a brief window, pre-peak of wave one, to optimise care for patients in the shielding/extremely vulnerable and high-risk groups. And they had to come up with guidance quickly to help clinicians safely triage, assess and manage patients with suspected Covid, remotely.

'It was a very uncertain time,' said Dr Chowla. 'We were seeing the birth of a new disease and, at the beginning, not really knowing what we were meant to do to look after our patients with suspected Covid, or how to organise ourselves to do so.

'Then lots of national groups started to put together Covid guidance and things quite quickly coalesced on a consensus of how best to assess and manage Covid patients.'

Mental healthcare providers have faced several challenges. Alice Forkgen, assistant director of contracting and transformation, North West Boroughs Healthcare NHS Foundation Trust, said the trust has been using video consultations to continue to provide services to patients. But it has also implemented enhanced physical health teams in its mental health wards to prevent patients having to go into acute settings.

Mental health demands

Like all mental health providers, it is braced for a surge in activity, but this may have started already. 'Recently, I've noticed a massive increase in mental health bed usage – so much so that we've been required to use an additional 12 beds from the independent sector, which for us is half a ward, so it's a lot. I don't think we've understood the impact of Covid on people's mental health; [there's been] an increase in anxiety and depression in people, especially those with long-term conditions.

'We've always known mental health is closely linked to long-term conditions, so I guess that's something we will see more of in later stages.'

The trust also provides 0-19-year-old services, including school immunisation programmes. During the initial lockdown, schools were closed, and even now children can be hard to reach, leading to concerns about the backlog and long-term impact of not being immunised at the right time.

HFMA ROUND TABLE

Pictured above l-r: Alice Forkgen, Ann Cole, Claire Wilson, Craig Mustoe

Left l-r: John Connolly, John Graham, Michelle Pilling

Below l-r: Rachna Chowla, Keith Wood, Sam Wilde, Nigel Foster

Many participants spoke of offering more care at home. Ann Cole, national evolving health manager at Baxter, said the company had developed homecare models to enable patients to manage their own condition.

'Patients are being trained to use the technologies to deliver their own dialysis, or to administer their own IV antibiotics,' she said. 'A number of these pathways have been advocated for many years, particularly the use of home dialysis. There are 20-plus years of Nice guidance or technology assessments.

'There are guidelines from professional bodies and patient bodies, yet we haven't seen any particular change to the overall prevalence of home dialysis. However, the Covid data shows significant disparity in infection and mortality rates that positively favour home therapies. We've seen an acceleration and uptake of this pathway, which enables social distancing, allowing patients to avoid multiple clinic visits per week and hospital transport, as they conduct their treatment in their own home. Remote patient management allows healthcare professionals to securely view individuals' recently completed treatment and act on information as required.

> **"There has been a fundamental shift in terms of virtual working, though it doesn't necessarily mean we won't bounce back to seeing people face-to-face"**
> **Claire Wilson**

'We saw huge change in the way services were configured, but also in the relationship between the NHS and industry – collaborating in a different way as partners to deliver these patient services; seeing pathways in totality rather than discreet episodes of care; and using data to inform care pathway transformation.'

Tackling inequalities

Covid has highlighted existing inequalities in access and outcomes, particularly for black, Asian and minority ethnic groups. John Connolly, group director clinical pathways at the Royal Free London NHS Foundation Trust, said this was the most important impact of the pandemic. 'That really focused us as an organisation.'

Performance metrics offered a way into tackling inequalities. The Royal Free had completed research showing people in communities facing inequalities are more likely to fail to attend outpatient appointments and more likely to attend A&E and have unscheduled care, he added.

'By factoring in addressing the vulnerable patients in our communities, we can improve performance. The way out of our performance challenge is to address those inequalities and rethink our pathways in response to that.'

Dr Connolly pointed to the overwhelming economic argument for addressing health inequalities. 'We need to change our mindset so we factor in the consequences of change before we make changes. We need to use data around inequalities to inform how we make changes rather than look at the impact after we've made the change.'

He added that while changes were necessary in the immediate response to Covid, there was a need to think about the long-term impact and to engage with local people on this.

'I have a deep concern about unidentified harm. A lot of our patients did not come to hospital and are still not coming. It's impossible to understand what's underneath the iceberg of unmet need – we really need to push on with pathway redesign to anticipate that. The question is what pathways have changed – I think every one has changed in some way.'

Michelle Pilling, deputy chair of East Lancashire Clinical Commissioning Group, said developments such as virtual clinics can benefit patients and systems. But she worried about vulnerable and older people, or those without access to smartphones or the internet, who the NHS risked leaving behind.

'Rapid discharge of patients can create problems of its own, as we have witnessed in care homes or in relation to continuing healthcare assessments, particularly around funding. Similarly, it has the knock-on effect of applying further pressure on different parts of the system such as primary care, for example.

'I want to ensure that, as we have these conversations, it is not just about finance. Efficiencies in hospitals can lead to bigger inefficiencies out in the community.

'And let's not lose sight of the human costs of this pandemic. To ensure we are designing quality pathways, we need to build patient experience back in, and quickly, alongside impartial lay oversight of the system changes that have taken place.'

Good-quality tools must be used to understand the impact of inequalities on care, she added. 'If we don't, all we're doing is shifting the problem down the road.'

Inequality can be created by language and cultural barriers. Sam Wilde, director of finance and business intelligence, Lincolnshire Community Health Services NHS Trust, described how it had addressed these obstacles.

'Some parts of our county have significant Eastern European populations, many of whom work in food processing. For a variety of reasons, they don't always access the healthcare services available. Some don't speak English, and many haven't experience of a healthcare system like the NHS. We've been sending staff into the food processing plants to speak to these people to explain what's on offer and how to access it. That has shown some real benefits.'

Looking to the future, the panel said the outcome of the spending review would be pivotal to post-Covid pathway development.

Keith Wood, senior finance manager at Suffolk and North East Essex Integrated Care System, said the service was at a critical point. 'Ultimately, the NHS pound can only be spent once. There is a very real risk that if the settlement isn't appropriate then instead of addressing those factors upstream that are going to lessen the flood, we will be too busy dealing with the tsunami coming through. All the resource will be committed to that, and that would be counterproductive.'

> **"It's impossible to understand what's underneath the iceberg of unmet need – we really need to push on with pathway redesign"**
> **John Connolly**

Block contracts were the best way to manage financial flows in this new environment. 'As a system for more than three years we have entirely run on blocks. It works because it focuses the mind on managing the costs and prioritisation of resource rather than growing the income.'

Voluntary effort

One of the most effective moves locally was putting funding into the voluntary sector, he said. 'It has achieved great things, including matched funding being put into the charitable sector. We all know the charitable and voluntary sector tends to deliver a lot more bang for the buck. But, unfortunately it comes back to the point that if push comes to shove and we are squeezed, we're going to have to look after those resources and services for which we are directly accountable, and that's massively counterproductive.'

A separate allocation to the voluntary sector would pay back many times.

Sam Wilde highlighted two key questions regarding finances: how much money would be made available and how would the financial framework operate?

'In simple terms, the NHS has pretty much had a year off from efficiency requirements in 2020/21. Will there be an expectation that this will need to be caught up, and if so, over what period? If we do try and catch up, and over a very short period, there is a significant risk we will end up doing some things that will be detrimental in the long term,' he said.

Chair John Graham spoke about the challenges of managing the estate during the pandemic. Like many others, his trust has established a hot and cold split in its emergency department, but it also needed to manage the use of the rest of its estate to prevent and control infections.

'We have all been doing dynamic risk assessments, which I know clinical colleagues probably do on a daily basis, but there are so many decisions being made and so many variables,' added Mr Graham.

Mrs Wilson said there will be ongoing costs from Covid in the new financial year, and for a number of years. Measures taken in hospital to control infection could affect productivity. It was vital systems understood their recurrent run-rate going into the new financial year and the impact of Covid. They must also understand non-recurrent costs such as social distancing premiums and the costs of dealing with the backlog activity.

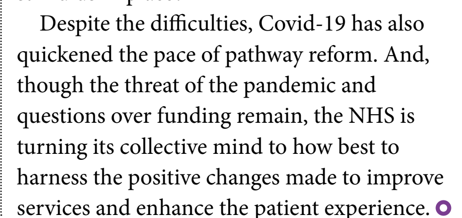
There will be an efficiency requirement in 2021/22, but finance teams must think about how they can engage with clinicians exhausted by Covid, she added. Focusing on waste reduction could be the answer.

Before Covid, the NHS had been planning to shift from being a treatment service to a self-care and prevention service. But Nigel Foster said Covid had 'moved the dial' back to being a reactive service. The NHS had a huge backlog of patients and a hidden demand of patients who had not yet presented for treatment.

'There is a risk that all our resources will be focused on dealing with the backlog, rather than moving the dial back,' he said. 'We've got to get ahead of the game here as we plan for the year or two ahead. How do we as a health and care system put enough resources into the bits that will keep our heads above water? Is it about prevention? Is it about self-care? Is it about identifying the patients who are at risk of deteriorating before they have deteriorated? It's going to be really important to ensure we ring-fence enough resource, planning and headspace for that piece of work.'

Craig Mustoe, Baxter's market access manager, said the NHS had wanted to change pathways for some time. 'I'm hearing Covid-19 has resulted in some positive change, but it hasn't solved all the problems.

'We can't just make changes all the time with the pandemic as the stimulus because it won't always be there. So what can we do to make sure that considered change can take place in an accelerated way, but also specifically facing the new challenges so we don't revert back to trying to solve the old problems because we no longer have that stimulus in place?'



Despite the difficulties, Covid-19 has also quickened the pace of pathway reform. And, though the threat of the pandemic and questions over funding remain, the NHS is turning its collective mind to how best to harness the positive changes made to improve services and enhance the patient experience.

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The big build

The NHS in England hopes to embark on one of its largest ever new hospital building programmes, which comes after years of capital being squeezed. Seamus Ward reports

The past 10 years have not been the most positive for healthcare capital spending. With austerity biting, capital funds were transferred to NHS revenue budgets to shore up day-to-day spending. The private finance initiative was ditched and PF2 came and is now seemingly gone, leaving behind only a handful of hospital-building schemes.

Carillion collapsed, leaving two hospitals under construction, though work has now restarted. Capital spending was squeezed, and trusts' use of internally generated funds restricted. Unsurprisingly, backlog maintenance in the NHS increased to £6.5bn.

But there have been recent signs that capital spending will recover and even increase – the biggest being the government announcement of the Health Infrastructure Plan (HIP).

The HIP, unveiled in September 2019, includes a plan to build 40 new hospitals, with the first opened by 2025. The idea is to create more certainty by introducing a rolling five-year programme of large hospital-building projects, together with capital to improve primary and mental health facilities and modernise diagnostics and technology. Estate safety issues would be eradicated, the government says.

The 2019 announcement was followed this autumn with more detail, but not necessarily more clarity. The headlines in the latest announcement said 48 projects are due to be open by 2030.

Under construction

However, a closer look shows four elements to the announcement. Four hospitals are already under construction, including the two delayed when Carillion went into receivership – the Midland Metropolitan Hospital and the Royal Liverpool Hospital. Four well-advanced projects are waiting for final approval.

While these eight projects are part of the hospital-building programme overall, 40 schemes are due to be built under the HIP umbrella. An initial six projects are in the first phase, which are scheduled to be open by 2025, though the Covid pandemic means this timetable could slip. There are 26 schemes in the second phase (HIP 2), with construction due to start after 2025 and delivery slated for 2030. A further eight schemes are still to be announced.

Some will have found the announcement of funding perplexing. When the HIP was announced in autumn 2019, £2.7bn was allocated to six schemes, with a further £100m of seed funding set aside for the HIP 2 schemes. However, in this October's announcement, it appeared the funding available for 40 projects would be £3.7bn. This included seed funding for HIP 2 projects to help develop strategic outline cases (SOCs). One of the HIP 2 trusts, Torbay and South Devon NHS Foundation Trust, hopes to submit its SOC in 2021, with its outline business case following in 2022.

The Department of Health and Social Care subsequently confirmed to *Healthcare Finance* that the £3.7bn announced includes £1.6bn of new money and covers the four-year spending review period 2021/22 to 2024/25. The additional funding is needed largely as a result of costs increasing as trusts refine their schemes through the outline and final business case procedures.

The West Hertfordshire scheme, for example (*see box overleaf*), was allocated £400m in the initial announcement. But, with the Department saying the trust could consider higher cost options, available funding has now risen to a potential £590m.

The Department also says that some of the initial £2.8bn would be carried over to the next spending review period, presumably to cover the costs of later than planned delivery or the timing of work on HIP 2 sites. For the sake of simplicity, it may be best to put aside this sum and concentrate instead on the £3.7bn allocated over the next four years.

As the funding is allocated for the period up to 2025, the funding should cover all or most of that needed to build the six hospitals under

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HIP 1, giving an average of £500m-£600m per hospital. The funding needed per scheme will depend on final designs and capital availability. Costs to the taxpayer could rise, given trusts' desire to meet net zero carbon targets, for example, or the need to adapt buildings post-Covid. On the other hand, trusts may be able to use internally generated funds or charitable contributions to reduce the need for Exchequer funding.

King's Fund chief analyst Siva Anandaciva says the HIP has, at least, introduced a degree of certainty. 'In the past, people were living from April to March, but in capital terms HIP sets the direction nationally, focusing on five-year chunks.'

But he is worried the focus of HIP is too narrow. He questions whether the annual capital departmental expenditure limit (CDEL) will be largely allocated to HIP spending, with little left for other priorities such as backlog maintenance, which in England stands at more than £6bn.

'The HIP acknowledges that NHS infrastructure is about more than just large hospitals,' he says. 'The health secretary has planned changes with primary and community estate upgrades and changes to the mental health estate, such as getting rid of dormitory accommodation. But there is a risk that the vast majority of the new money on the table will be dominated by the new hospital-building programme rather than wider infrastructure priorities.'

He adds: 'We need a health and care capital strategy, and initial funding for the HIP seems narrowly focused around a hospital-building programme. It doesn't change the need for wider investment in out-of-hospital care.'

Mr Anandaciva says the *NHS long-term plan* has signalled a move to delivering more care in the community and in GP surgeries, but this cannot be achieved without a capital investment plan. 'The plan is to have more care in the community and for that to happen we need changes in investment in the estate. Part of this will be re-imagining the estate to support greater multidisciplinary working.'

Rebuilding or repurposing existing buildings in the community will not have the same political cachet as cutting the ribbon on a multi-million-pound hospital, he says, but the community and primary care estate must be part of a capital investment strategy if the long-term plan is to be delivered.

Whipps Cross project

Like many NHS hospitals, London's Whipps Cross Hospital, part of Barts Health NHS Trust, urgently needs redevelopment. A scheme that would see a new hospital built on the current site while services remain open, was named as a HIP 1 development. The new hospital would deliver services currently offered at the site, including A&E and maternity, with the trust committed to establishing the hospital as a

West Herts scheme

Like many of its peers, **West Hertfordshire Hospitals NHS Trust** has been planning building improvements for many years to replace ageing buildings, unfit for purpose or with high maintenance costs, and to expand capacity. But its plans have failed to get off the ground, falling foul of the capital squeeze on the NHS following the global financial crash of 2008 or new government policies. But as one of the six first phase HIP schemes, it has hope.

The trust is working its way through the outline business case (OBC) stage of the approval process, which it is aiming to finalise in 2021. As part of the OBC, the trust and the local **Herts Valleys Clinical Commissioning Group** have selected a preferred option – a complete transformation of the Watford General Hospital site and improvements at Hemel Hempstead and St Albans City hospitals.

The trust and CCG boards decided against building on a greenfield site after receiving an independent report that calculated the risks as being higher than redeveloping the Watford site (pictured). The potential risks included the need to purchase

land and get planning permission, together with highways and access issues, which could all add up to considerable delays.

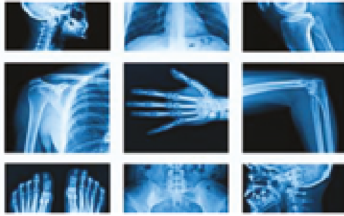
If approved, the Watford project would create a new clinical block, replacing almost all clinical facilities on site. Almost all inpatient beds would be in single-occupancy rooms. Hemel Hempstead would get a purpose-built urgent treatment and diagnostics centre, bringing together outpatients and focusing on medical specialties and long-term conditions. The St Albans City Hospital, which is the trust's designated Covid-free site, would be enhanced to continue providing planned surgery and 'one-stop shop' clinics to speed up diagnosis.

Covid-19 has affected the trust's thoughts on hospital design, including the need for single rooms, the application of digital technology and the amount of space needed, given that some aspects of services will remain online post-Covid. But the scheme is subject to a judicial review, the outcome of which is due this month.

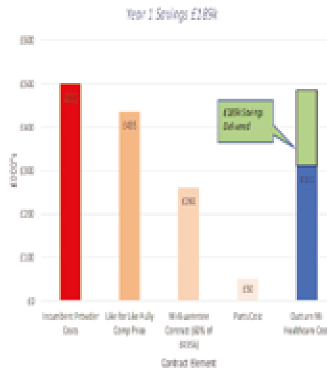
Overall, the scheme could cost £590m – £540m for the Watford building work and £50m for the work at the other two sites. However, the trust has said it will, like all NHS providers, be working to achieve zero net carbon and invest in its IT, and is working to understand the total funding required through its OBC process.

When the scheme was included in HIP in 2019, its cost was put at £350m-£400m. This has been revised up. The Department of Health and Social Care wrote to the trust to support three options with projected costs of £300m-£590m, including the preferred option. But it insisted that any option of more than the indicative funding envelope of £400m would not necessarily be nationally affordable or supported.

Even so, the £400m should not constrain any proposals – deliverability, completion by 2025 and cost-effectiveness were key to any scheme coming forward, it said.



Advertorial Feature



Delivering £1m of Savings In Diagnostic Imaging Maintenance Contracts

Health systems continue to face unparalleled challenges in balancing capacity, patient access, quality and finances. ***Mi Healthcare*** *have an innovative, unique solution* ***MI Guarantee*** *to support delivery of these priorities within diagnostic imaging,* ***saving £1m over a 5 year contract.***

A major NHS provider organisation have banked £0.4m of savings and are on track to save almost £1m over the next 5 years since changing the providers of their tier 2 diagnostic imaging maintenance contracts to Mi Healthcare.

Mi Healthcare, a framework provider, with nationwide engineering coverage have delivered the specified services for c£0.2m per annum less than the hospital's incumbent service providers achieving a 38% saving.

Furthermore, as the provider have consolidated their service provision through Mi Healthcare they have been able to work closely with a sole provider to develop an excellent relationship and see an improvement in response rates to repairs, normally the same day and always the next day, the level of first time fixes (averaging 93%) and increased system availability to 98% across the portfolio.

The relationship, performance and financial improvements have been achieved through the **Mi Guarantee** contract, the key features of which are:

1. A fully comprehensive maintenance contract with a fixed upper cost level to mitigate cost risk of potentially costly repairs, and
2. The de-coupling of the costs of all elements of service provision from the cost of parts required for reactive repairs to create a "parts pool" a 60:40 split, creating a risk free upside savings opportunity of up to 40%, only paying for parts as used rather than upfront and irrespective of use or cost of parts.

As a result of the move to Mi Healthcare the provider reduced their costs from £500k to £311k saving £189k per annum. Against this backdrop a longer term, 5 year, contract was agreed to deliver £175k savings per annum recurrently over the life of the contract.

At a time when the capacity of critical diagnostics, in support of effective, highly quality and efficient patient pathways, may be reduced and severely tested as we all adapt to post Covid-19 service management it has never been more important that healthcare capacity is up and running, maintained appropriately and available for patients when its needed.

The Mi Healthcare team through the Mi Guarantee contract have delivered this in partnership with imaging departments and will be able to do so for your organisation too. Contractual savings opportunities can be amongst the quickest and simplest to deliver and as a NHS Supply Chain framework provider, available to all organisations.

Alistair Mulvey

Director Healthcare Strategy & Collaboration
Alistair.Mulvey@mihealthcare.co.uk.

centre of expertise for the treatment and care of frail and older people.

'The case for investing in a new hospital at Whipps Cross is compelling and undisputed,' says Adeeb Azam, associate director of finance for the development. 'North East London has one of the fastest-growing populations in the UK. We expect the number of people in the Whipps Cross catchment area to grow by more than 10% over the next 10 years, and the number of older people within that to increase by a quarter.'

Almost half the current hospital pre-dates the foundation of the NHS itself. 'If there was no new building, the existing estate would require £170m worth of backlog maintenance to bring it up to an acceptable, but not new, standard – one of the largest backlog bills in the NHS,' he adds.

When inflation, and other factors such as improved building insulation, are added in, the backlog maintenance costs rise to circa £380m. And even if that was addressed, it would not change the legacy of the existing layout. Services are sprawled over the site, so staff and patients have to travel between them. This is inefficient and means enhanced risks to safety, privacy and dignity, as well as infection control, says Mr Azam.

The proposed new hospital would be at the centre of a new health and wellbeing setting, with much needed new homes and other facilities. The redevelopment of the site as a whole would stimulate further economic growth in the area, bringing jobs and businesses, the trust believes.

The work is backed by Waltham Forest Council, closely aligned with local clinical commissioners, and a top priority of the East London Health and Care Partnership for capital investment.

The cost of the scheme is yet to be finalised, with the trust working on its OBC and detailed designs. The trust's strategic outline case has been approved by the Department, along with confirmation that it can proceed to the OBC stage. This includes an agreement to fund the costs of taking forward the OBC programme over 2020/21.

As with all schemes at this stage, the overall capital requirement from government will be subject to approval by the Department and the Treasury as part of the OBC approval process.

The trust expects the project to be funded in the form of public dividend capital (PDC). Mr Azam says it is also looking at other sources of finance. 'The redevelopment will include land sales, which will contribute towards funding the new hospital. In addition, we are exploring funding sources such as charitable donations, which could also reduce the overall PDC funding required from the government.'

The OBC process will be an opportunity to test the projected timeline for delivery of the project.

Mr Azam says that, subject to planning permission, business case approvals and further detailed work, the construction of a new hospital could begin in autumn 2022. 'We anticipate it will take around four years to build, in a single phase, with the current hospital remaining operational throughout. We will test this assumption as part of developing our OBC. Ahead of that, we are undertaking a programme of enabling works to prepare the disused site of the former nurses' accommodation for the construction of a new hospital. We expect to begin demolition of redundant buildings in early 2021.'

Mr Anandaciva says Covid has had an impact on the HIP hospitals, as it has with virtually all aspects of the NHS. 'If you are trying to build up Covid resilience, you would definitely be looking at things like more self-isolation rooms,' he says.

'If you are building a hospital now, you've also got to ask what the needs of patients will be in 10 years' time. What are you planning for your outpatient department if the use of virtual appointments continues to grow? Will the needs be the same? Increasingly, people seem to be talking about adaptive and flexible spaces in their designs.'

Indeed, Barts feels that Covid-19 has reinforced its plans for Whipps Cross. It has already put in place positive changes on the current site that it has proposed for the new hospital. And it expects to make further changes in response to the expectation that more people will attend services following a referral from GPs or NHS 111. Its early assessment is that more single rooms, more entrances and greater flexibility to partition space in different ways will be needed.

The HIP is a welcome boost for local NHS services, with an initial six hospitals to be redeveloped and 34 in the pipeline. But questions remain: will the plan be thrown off course by economic uncertainty? And will the required funding be available – both for the large hospitals, and primary and mental health schemes, and to tackle the backlog maintenance in other providers?

The business case process

There are **three stages** to the business case process, and for schemes valued at more than £50m, approval is required at each stage from bodies including the Department of Health and Social Care and, ultimately, the Treasury. Commissioner support is also required before moving onto the next stage.

The Treasury's five-case model – providing the strategic, economic, commercial, financial and management cases for the proposed development – should be followed at each stage. The process starts with the **strategic outline case** (SOC), which establishes the case for investment, assesses the main options and provides a recommended or preferred way forward.

The second stage – the **outline business case** (OBC) – is more detailed, reviewing the SOC longlist of options and checking the preferred way forward remains valid. The OBC should include a link between clinical and workforce strategies, while financial and non-financial impact should be assessed.

The final stage, the **full business case** (FBC), should update the content of the OBC and address any concerns raised at the OBC stage. It should also show that activity and capacity planning assumptions and modelling are consistent with the delivery of the clinical strategy and align with workforce plans, service developments and efficiency programmes.

HIP 1 trusts are at different stages, mostly at OBC. The West Hertfordshire development hopes to conclude its OBC next year, while The Leeds Teaching Hospitals NHS Trust OBC has been approved by the Department.

Annual review

2019/20

hfma

President's and Chief Executive's Report

The year to 30 June 2020 was the third and final year of the current three-year strategy. It was not the year that we expected with the onset of the Covid-19 pandemic which has devastated the lives and livelihoods of millions.

Up to March 2020 the business plan was being delivered. However, during March 2020 as a result of the impact of Covid-19 this changed; all our staff moved to working from home, all face-to-face events were cancelled or moved to being run as virtual events, the conference centre 110 Rochester Row was closed as directed by government and planned summer student intakes were deferred to the autumn.

Despite the challenges HFMA continued to operate and, indeed, the outputs from our policy and technical team increased as did the number of webinars and other on-line activities. Our free bitesize e-learning modules, which are on the NHS ESR system, went live and the usage took off. In addition, the website was refreshed so that all Covid-19 related content was placed in a special portal with free access to all. The way this happened almost overnight is a testament to the HFMA team who pivoted the organisation to make it fully virtual.

If we did not know it already, we were reminded how resilient and supportive the NHS finance function is. With numerous messages of support and useful suggestions as to how HFMA could assist and support the finance community across the NHS, the association was able to tailor its work programme accordingly. In 'normal times' this support has been the key to HFMA's success. In these extraordinary times, the time and energy that HFMA's volunteers and membership have put into the association has ensured we have survived and are able to move forward with confidence.

By providing such a huge extra amount of support the association was also able to provide a significant increase in public benefit as evidenced by, for example, the increase in social media traffic and downloads of material. So, a huge thank you to all those who made that happen and for helping us get through this extraordinary period. This has allowed us to achieve all the success we have this last year.

One way we can measure these successes is through our key performance indicators, which we measure ourselves against each year. These show that at the end of 30 June 2020 we had reached a record 16,666 members and supported them and others through:

- 152,609 hours of CPD provided during the year
- 139 regional and national events including webinars
- 51 briefings and publications.

We ask attendees and users of all our activities to give feedback and over the last year we achieved an amazing 97% 'good' or 'excellent' on events and 95% from everyone who undertook e-learning. We are very proud of this feedback. During the year to 30 June 2020 we also continued to host, work alongside and support Future-Focused Finance (FFF) with the delivery of its programme of work.

However, despite all of this hard work we have been hit hard financially by the impact of Covid-19 with a loss for the year of £779k. Although the reserves built up over the years mean HFMA can 'ride the storm' this has resulted in the need for some restructuring to allow HFMA to be sustainable for the future. The reserves on 30 June 2020 stand at £3,606k.

The trustees also recognise that the future is very uncertain and therefore rather than set the new three-year strategy from 1 July 2020, it has been decided to wait a year. The year to 30 June 2021 will be one of reassessment with a recognition that there is a need to be nimble and flexible as we learn what the 'new normal' looks like in the Covid-19 world we now live in. We will use the second half of the next financial year to set a new three-year strategy for the three years from 1 July 2021 to 30 June 2024.

We would like to take this opportunity to thank our friends on the corporate partner programme – all 22 of them – who provide us with valuable resources, without which we would not be able to run our central infrastructure. They, along with all our commercial supporters, continue to be very supportive in these challenging times for which we are very grateful.

Bill Gregory was the President for the first half of the year and his theme *Value the opportunity* was a message that matched the times. We would like to thank Bill for the steady and supportive leadership he brought to the role over the year.

The theme for the second half of the year, launched at the annual conference in December 2019, is *Taking pride in our future*. This is a theme that's been embraced by the finance community and one that particularly resonates with the way the country has rallied around the NHS since March 2020.

We are so proud of the contributions made by the NHS finance community to keeping the NHS show on the road and supporting our clinical colleagues throughout the pandemic. There's loads more to do, and right now the future looks very different to how we thought it would look at the beginning of the year. But we will be a big part of designing it and making sure that we keep the best of what we've learned to help the NHS recover and renew.

Thank you for reading this annual review. As always, please do not hesitate to contact us with any comments or thoughts and our best wishes to you all.

Caroline Clarke
President

Mark Knight
Chief Executive

Total number of HFMA members:

16,666

a **6%** increase on 2018/19

(2018/19 15,716)

Highlights

Launched HFMA bitesize a range of online CPD accredited courses

Removed plastic waste from *Healthcare Finance* magazine mailing and introduced a new weekly news email for members

Opened up publications and news content to all and published an extensive series of briefings, webinars and podcasts to support our community through the pandemic

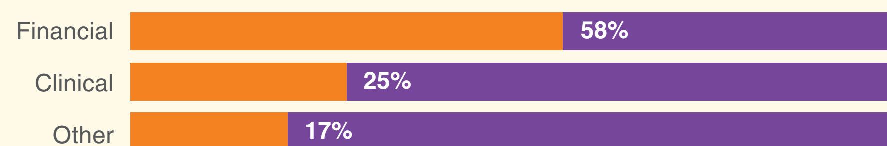
HFMA Qualifications

7 learners completed their MBA with BPP University

110 learners completed a qualification

540 learners enrolled in the qualifications **+34%** from 2018/19

Breakdown of learners



Financial Management Training

In September 2019, eight new trainees joined the Finance Management Training Scheme (four in the South West and four in South Central). September also marked the completion date for the 2016 intake. All West Midlands and four out of five South West trainees have secured substantive roles in the NHS.

The scheme received a total of **230 applications** for the 2020 intake, which was shortlisted to eight trainees who started the scheme in September 2020.

The policy and technical team

51 publications

10 consultation papers

24 **HFMAtalk** podcast episodes

Skills Development Network

4,000 CPD hours — 515

The South West Skills Development Network delivered 30 events as part of its 2019/20 programme, welcoming 515 delegates and delivering over 4,000 CPD hours to the region.

4,200 CPD hours — 529

The West Midlands Skills Development Network provided approximately 4,200 CPD hours to the region through its 2019/20 programme. These events reached 529 delegates over the course of the year.

3,000 CPD hours — 380

In the **South Central region**, 29 organisations contributed to the SDN levy. A total of 25 events were delivered as part of the 2019/20 programme, reaching over 380 delegates and providing approximately 3,000 CPD hours.

Commercial

Supported by **22** corporate partners

110 Rochester Row, our conference centre in London, continues to be a successful investment for HFMA

Website visits

Total Page views

627,369	on 2018/19	+12%
65,425	on 2018/19	+30%
74,480	on 2018/19	+16%
14,637		+7%

Learning and development

152,609 hours of CPD provided during year

97% good or excellent feedback received on our events

139 regional and national events and webinars

HFMA held **46** webinars with over **9,000** attendees

FFF

During 2019/20 we continued to host the Future-Focused Finance (FFF) programme and committed £100k of our resources to support the initiative. The programme has gone from strength to strength, with amazing growth in the number of Value Makers, Finance and Clinical Educators and organisations gaining accreditation. We know that this growth represents the commitment across the service to developing ourselves and improving the service we offer to support the good health of our populations.

HFMA bitesize

HFMA bitesize launched and **40** e-learning short courses rebranded

40+ intermediate and advanced courses released

31,600+ courses assigned to learners and **7600+** courses completed

22 courses were made available free of charge to the NHS and **4600+** courses have been accessed since their release in March

733 learners completed the Introductory Award in Healthcare Finance

Annual conference

- HFMA president Caroline Clarke, launched her theme **Taking pride in our future**. Due to the restrictions of the pandemic Caroline will be the first ever President to undertake a two year term of office
- BBC Europe Editor, **Katya Adler**, closed the HFMA annual conference 2019

Branches

The **South Central branch** annual conference and awards welcomed 102 delegates in September, providing 1,326 CPD hours.

In September 2019, 247 delegates attended the **South West branch** annual conference. The conference received 99% excellent/good feedback.

The **West Midlands branch** 2019 annual conference in June, welcomed over 300 delegates. The branch also held an efficiency and innovation event in collaboration with the Healthcare People Management Association.

133 delegates attended the **North West branch** conference in 2019.

The **Wales branch** welcomed 250 delegates to its annual conference in September 2019, providing 1,875 CPD hours, and raising £1,345 for Cancer Research Wales in the charity raffle.

Hannah Witty, chief finance officer, Central and North West London NHS Foundation Trust, took over as chair of the **London branch** in 2019. The branch hosted a number of events, including their annual conference.

111 delegates attended the **Scotland branch** annual conference in October 2019.

The **East Midlands branch** annual conference and awards in November was attended by a record 144 attendees, and included a student forum, facilitated by the Skills Development Network.

The **Yorkshire and Humber branch** annual conference took place in January 2019 and welcomed 184 delegates.

The **Eastern branch** hosted an *Introduction to NHS finance* event in January which delivered 240 CPD hours. The annual conference welcomed a record 134 delegates, and achieved 100% excellent/good feedback.

The Kent, Surrey and Sussex branch annual conference in October, themed *To infinity and beyond – transforming healthcare* welcomed 175 delegates.

The **Northern Ireland branch** continues to deliver pertinent and well attended CPD events.

The Northern branch welcomed 297 to its annual conference in November 2019. In June 2020 the branch hosted two virtual events with the SDN.

Policy and technical

During 2019/20 HFMA's policy and technical team produced 51 publications and submitted 10 responses to consultation documents issued by stakeholders. For the first eight months of the year we delivered our agreed work programme until the impact of Covid-19 was evident. From March 2020 all non-urgent policy work was suspended and we focused on supporting NHS finance staff during the pandemic.

We asked members how best we could help them. Consequently, our main areas of focus were: briefings; podcasts; webinars and the creation of an NHS finance discussion forum portal. All of the HFMA's Covid-19 related outputs were openly available and not restricted to HFMA members.

We produced a range of briefings on technical matters aimed at supporting members as they go about their work. The topics covered included accounting for leases, the NHS pension scheme, external audit, going concern and costing. During 2019/20 we updated the *Practical guide to NHS charitable funds* and we published a discussion paper on the future of the NHS financial regime, which considered the changes needed to make the best use of scarce NHS resources, work on this will continue into 2020/21.

Our Covid-19 related work focused on the finance and governance issues raised by the pandemic and included summarising the guidance issued by NHS England and Improvement, advice when accepting gifts or donations and a checklist of financial governance considerations. We also produced a range of briefings to help finance staff work effectively during the pandemic, including tips for working from home and how to get the best from Microsoft Teams. The HFMAtalk podcast featured a wide range of interviews providing different perspectives on the pandemic and we hosted regular webinars enabling senior finance leaders at NHS England and Improvement to talk to finance directors as the finance response to the pandemic was being developed.

Our range of 'maps' continued to be popular, with the NHS efficiency and NHS corporate governance maps being regularly updated during the year. We added a Covid-19 guidance map to the range and updated it on a weekly basis during the height of the pandemic.

The reach and depth of HFMA networks provides us with invaluable expertise and knowledge, adding value to our collaboration with a wide range of partners. For example, we published a report with FFF reviewing the future of the NHS finance function, we worked with CIPFA to update the glossary for NHS and local government finance and carried out research with ACCA exploring the role of NHS finance business partners.

We are grateful for the continued support from, and expertise of, our committees and groups, which contribute to the thought leadership of the association and allow us to produce a wide range of high quality publications and briefings.

Our networks

The summer conference in July 2019 welcomed over 150 delegates and focused on integration, prevention and technology as its overarching themes. Keynote addresses from bodies such Public Health England, NHS Digital and NHS England and NHS Improvement were blended with detailed NHS case studies and an examination of personal health budgets through the eyes of a patient with long-term complex co-morbidities.

The Provider and Commissioner Networks came together in September to host an event on the value of community services, supported by the HFMA Healthcare in the Community Special Interest Group. This theme of collaborative working and bridging care setting divides continued with the November commissioning forum focusing on primary care networks, and the February integration summit focusing on integrated care systems and the progress towards national coverage by April 2021.

The highlight of the year for the Mental Health Network was the annual mental health conference in November 2019. Professor Tim Kendall, National Clinical Director for mental health at NHS England and NHS Improvement set out a clear vision for the future of mental health services, which was followed by an inspiring story of rebuilding a community and adapting how we bring together physical and mental health services after the Grenfell tower disaster.

The networks continued to work closely with those in senior finance and leadership roles in the NHS this year. At the forum and networking dinner for finance directors and chief finance officers in January 2020, Dr Robert Varnam, director of professional leadership for improvement directorate discussed how NHS England and NHS Improvement can help national, regional and local leaders make better use of resources. Natasha Curry, deputy director of policy at the Nuffield Trust highlighted what we can learn from care systems in Japan and Germany. Sir Simon Stevens, chief executive officer of the NHS, gave a national update to an audience of NHS chief executive officers at the February 2020 CEO forum.

The Chair, Non-Executive and Lay Member Network hosted forums, an audit conference and a chair's conference this year. Uniquely in comparison to other NED networks, this network is open to all board members from across clinical commissioning groups and provider organisations and includes specific events for NHS chairs and audit committees. The content for the network is also shaped and influenced by HFMA's Governance and Audit Committee, with members from within the NHS, the National Audit Office and public sector auditors.

The Healthcare Costing for Value Institute continued to support those with involvement or interest in costing through its introductory and technical costing events, webinars, and publications, and in value through the 2019's international symposium and value challenge project.

A key achievement for the institute this year was the successful completion of the pilot stage for its Engagement Value Outcome (EVO) framework. The framework was tested with four NHS trusts, covering acute, mental health and community services. Each trust was awarded bronze EVO accreditation, all participants were made EVO ambassadors and the institute published a detailed case study on each of the four pilot sites. We are now working on the next phase of the framework. Applications will open in 2021.

At the beginning of 2020, the Covid-19 pandemic started to spread in the UK and the HFMA networks could not continue to deliver their event programmes as planned. Focus was given to webinars, online content and policy resources that could best help our NHS members and partners at this time. Healthcare in the UK and globally is going to be forever changed by Covid-19, and the way that professional bodies such as HFMA interact with and deliver content to its members will have to adapt and evolve. The networks are continuing to be proactive and flexible in order to meet these challenges.

Despite the extreme difficulties and challenges brought on by the pandemic, it has also acted as an accelerant for the kind of technology focused transformation and collaborative care that our healthcare service has been striving to implement these past years. In a similar way, the pandemic is propelling the HFMA to focus on the use of technology and on the benefits of a balance between face-to-face, virtual and hybrid events. It will be important to acknowledge which changes brought on by the current climate bring better value to our members, and to continue embedding those in the future.

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nurturing growth

While providing healthcare is the core role for NHS bodies, many are increasingly aware of how they can support economic and social recovery in their local areas. Steve Brown reports

Everyone understands that the economy has a massive impact on the NHS. As NHS England chief executive Simon Stevens famously said: 'When the British economy sneezes, the NHS catches a cold'. But this is not a one-way street and there is a growing realisation of the important role the NHS can play in both local economic and social recovery – something that will be even more important post-Covid-19.

There are already examples of health bodies around the country that are factoring in local social and economic impact to their decision-making, as well as thinking through their impact on the environment.

There are NHS trusts delivering services and running facilities that are outside the direct delivery of healthcare. Others are embedding the delivery of social value into core procurement decisions. And with the current priority being given to addressing health inequalities and the wider determinants of health, some organisations are recognising that this may start with ensuring their own staff have good employment terms and conditions.

In September, the NHS Confederation published *Health as the new wealth: the NHS's role in economic and social recovery*. The report, part of the confederation's *NHS reset* campaign, acknowledges that the role of health in economic development has traditionally been peripheral at best. But a consequence of the pandemic is that it will likely form a 'more important and explicit part of national and local rebuilding'.

This view builds on the recognition that NHS bodies are powerful anchor institutions – large public sector organisations that are unlikely to relocate and have sizeable assets and resources that can be used to support local community wealth building.

While local government and universities have been more typically identified as anchors, the *NHS long-term plan* promised to explore the potential of the NHS as an anchor institution, highlighting examples of where NHS bodies had created social value in their local communities.

The confederation report identifies five steps that will help local economies play their part in this recovery, including filling vacancies with local people and using new local supply chains.

But at their core, all the steps involve recognising the broader impact of actions and decisions. They are about focusing on value delivery – but value in its broadest sense including the benefits to local social and economic wellbeing.

This is not simply an altruistic gesture. A thriving local economy – and one where inequalities are addressed – will deliver health gains to local residents that will have knock-on benefits for generations and potentially reduce demand for healthcare in future.

Employment

NHS bodies are already having a significant impact on their local economies just by being such major employers – responsible for up to 10% of employment in some sustainability and transformation

SHUTTERSTOCK

partnership (STP) areas. The Health Foundation's report *Building healthier communities: the role of the NHS as an anchor institution* underlined the importance of this being 'good work'. That means providing stable employment, paying a living wage and offering fair working conditions. While much of this is taken care of by national terms and conditions for NHS staff under Agenda for Change, there are areas where NHS bodies can make a difference.

Imperial College Healthcare NHS Trust has just this year brought its hotel services back in-house. Its former contract had been due for renewal and the trust had been stipulating that staff should be paid the London living wage as a minimum. But on further reflection, it decided to move to direct provision, to be reviewed after a year.

As part of the new arrangements, porters, cleaners and catering staff initially moved from a minimum wage of £8.21 to the London living wage and then to NHS rates from April – with a minimum of £11.28 per hour, including the high cost area supplement. Although the staff are not currently on full Agenda for Change conditions, they do qualify for sick leave and pensions.

The move by the trust was about getting proper engagement with staff and treating them fairly, ensuring they felt properly valued and part of the team, and enabling improvements in quality.

However, Michelle Dixon, director of communications, says the trust has been looking into what being an anchor organisation means for an NHS body. The insourcing was not a direct result of this. 'But we refreshed our strategy about 18 months ago and our vision is "better health for life". That is a shift for a big teaching hospital like ours – we are looking to take a much more population approach to health,' she says. 'And within that, we are thinking about our staff as a population.'

Social front door in the community

Libraries have always been at the heart of local services, but funding cutbacks in recent years have forced significant closures. Five years ago nine out of 19 libraries were at threat across Liverpool – including the historic Carnegie Walton library. That was until Mersey Care NHS Foundation Trust came to the rescue.

The building was converted into new Life Rooms – the first of five such centres that are now open, providing opportunities for learning, recovery, health and wellbeing. In Walton, the arrangements include retaining some of the former local library services.

The purchase was born out of a major listening exercise in which trust patients made it clear that addressing some of the wider determinants of poor mental health was as important as providing excellent clinical services. So Mersey Care wanted somewhere people could go to get help with housing or benefit issues or access learning opportunities.

'But at the same time, we were also hearing about the shock and fear among service users about the proposed closures to libraries across the city,' says Michael Crilly (pictured), the trust's director of social inclusion and participation. 'Libraries have long been about more than books.'

He says mental health service users value libraries as somewhere warm to get away from poor accommodation. They can access them freely to do a daily job search or to deal with a benefit issue. 'Access to IT becomes a big deal, as does finding the bus fare to the library down the road [if your local branch closes],' says Mr Crilly.

So there was a compelling argument for taking over the library – which is in one of the poorest wards in the country with a high incidence of mental distress. And that's what happened in 2015, with the new Life Rooms opening in May 2016 – open to all local residents, not just trust service users.

Carnegie Walton library, now Life Rooms
Inset: Mersey Care's Michael Crilly

From its five centres, Mersey Care now offers an extensive curriculum of around 60 courses, for example helping people with confidence, anxiety and self-esteem. They also provide a centre for local social prescribing advisers to signpost service users to wide-ranging activities.

Mr Crilly says the programme has been hugely successful – with growth far outstripping expectations. 'We couldn't have anticipated the demand across our communities,' he says.

He believes the model of having a social front door in the community is attracting interest elsewhere. 'By looking at social issues initially, you begin to triage down the demand on clinical services,' he says.

The project is all about social recovery, he says – social recovery supporting economic recovery will further enhance local wellbeing.

And the central location of Life Rooms means the trust is encouraging more footfall on high streets, which can itself make a contribution to economic recovery.

The Life Rooms have been closed since March because of Covid-19. But they were attracting 5,000 visits a month at that point and an outreach service has been put in place for users on a clinically vulnerable list.

Mr Crilly admits that the outcomes can be difficult to measure in the short-term – although there is no shortage of qualitative data. 'We evaluate it using the NHS personalised care framework for social prescribing, so we look at the impact for individuals, for communities and for systems,' he says.

There is early evidence that healthcare costs go down for Life Rooms users in general, but there is also a cohort of service users for whom costs have gone up – believed to be linked to earlier engagement.

He says that while the original business case required a bit of a leap of faith, there is growing recognition from commissioners, and at the system level, of the value delivered by taking a broader view.

In Walton, it looks like a win all-round. The community has retained some of its library services – in a historic but refurbished building – and the trust has developed a service that is helping support both social and economic recovery.

With 1,000 staff involved across the trust's five sites, it certainly improves the financial position of a section of the community, which is likely to have benefits in terms of their health and wellbeing.

The NHS Confederation's head of health economic partnerships, Michael Wood, is full of praise for the move and says that it is important to see the value being delivered, not just the cost. 'Some might see this as a cost – having to pay £3 per hour more for all the staff,' he says. 'But most of that money will remain in the local economy.'

Better pay and treatment of staff is likely to have a positive impact on recruitment and retention, he adds, which may avoid some costs and enhance quality.

Mr Wood thinks all public sector bodies should review this, especially with ongoing concerns about in-work poverty across the UK in general. 'There is something about moral leadership,' he says. 'If the NHS and the public sector in a recession aren't going to take a first step, how can we expect private enterprise to do it?

'This is moral leadership and we are one of the few sectors that benefit directly from people being in work as it reduces our demand. So if you believe in prevention and population health, then paying our staff the living wage is one of the most important things we can do.'

Mr Wood also wants trusts to prioritise local recruitment wherever possible, particularly focusing on those out of employment or exiting the government's furlough scheme and at risk.

"If the NHS and the public sector in a recession aren't going to take a first step, how can we expect private enterprise to do it?"
Michael Wood, NHS Confederation

Procurement is another major area where NHS bodies can have an impact on their local economies, either by requiring suppliers to deliver social value as part of their contracts or by buying more locally.

The routine delivery of social value alongside all contracts should have moved a step closer when the *Public Services (Social Value) Act* came into force in 2013, requiring all public service commissioners to think about how they can secure wider social, economic and environmental benefits. However, despite the requirement being included within the NHS standard contract, social value has not really become embedded in the procurement process.

As of January 2021, central government will be required to explicitly evaluate social value in all major procurements, rather than just consider it, which may give the issue a higher profile.

However, there are examples of organisations demanding more social value deliverables from procurement. When the former Nottingham City Clinical Commissioning Group was looking to re-procure out-of-hospital community services for a contract starting in July 2018, bidders were asked not only to deliver efficiency savings, but also maximise social value. What makes the procurement stand out is the weighting given to social value in the bid assessment process. At 25% of the score, this was the same weighting given to the delivery of financial requirements.

Bidders for the contract, worth more than £270m over nine years, were asked to demonstrate how their bids would improve employment and training, promote healthy lifestyle behaviours and support a healthy environment.

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Arden and Greater East Midlands Commissioning Support Unit managed the procurement. Emily Armstrong, the CSU's associate director of procurement, says there would often be something in contracts about the delivery of social value. But awarding 5% of the assessment to social value was a more typical level.

Bidders – Nottingham CityCare Partnership Community Interest Company and an NHS provider – took the requirements very seriously. 'They talked about collaborating with local partners on health lifestyle initiatives, investing in the voluntary sector and focusing on the number of apprenticeships and training places offered,' says Ms Armstrong.

'They also committed to people being paid the living wage across the supply chain and reductions in carbon dioxide emissions. It was considerably more detail from both bidders and more well thought out than I'd seen before.'

At the NHS Confederation, Mr Wood, although not familiar with the specific deal, says the high weighting given to social value was a 'great statement'. But there are other examples of NHS bodies looking for contractors to deliver more than the core service.

Humber Coast and Vale Health and Care Partnership has also set out its stall to engage with this broader agenda. Director Chris O'Neill (pictured) acknowledges it is not straightforward. With a background in the acute sector, he is well aware that there is often only enough money and bandwidth to deal with immediate pressures. But the overall goal should be to develop a virtuous triangle of better health and wellbeing, improving quality and more efficient services.

For this integrated care system, which stretches along part of the east coast of England and both banks of the Humber, capital development is being used as a starting place for work on the wider agenda.

'If organised optimally, this could generate economic and social value and improvements in sustainability. And it could help with the research and innovation agenda – as well as replacing old buildings and helping with the quality and efficiency of the services provided,' says Mr O'Neill.

It is easy to hand a lot of responsibility for planning a project to a development partner and lose some control as a result, he adds. Instead the aim should be to exert influence not just over who builds your project, but how it is built and how the project is run.

The partnership has adopted and tailored established social and economic metrics for use within capital schemes. These are based on the national Themes, Outcomes and Measures (TOMs) social value measurement framework, which provides indicators in five key areas:

Jobs:	**Promotion of local skills and employment**
Growth:	**Supporting growth of responsible regional business**
Social:	**Developing healthier, safer and more resilient communities**
Environment:	**Decarbonising and safeguarding our world**
Innovation:	**Promoting social innovation**

The framework has been used to produce an initial estimate of the economic return on investment to the Humber area associated with larger scale capital development projects. For example, the partnership has undertaken early stage planning into the reprovision of Scunthorpe Hospital and moving services out of the upper floors of a 14-storey tower block at Hull Royal Infirmary.

The framework has also been used in a project looking to redevelop the campus at the Humber Teaching NHS Foundation Trust. This project for the mental health services provider has been worked up for possible inclusion in wave 2 of the national Health Infrastructure Plan programme (*see page 17*). Bidders for future projects would be expected to sign up to the delivery of agreed targets in these areas and the metrics will be used to monitor that delivery.

The routine delivery of local social and economic value won't be achieved overnight and while capital is seen as a good place to start, capital schemes inevitably have a long lead time.

But Mr O'Neill believes there may be opportunities to generate additional economic and social value through more day-to-day activities too. 'I am hoping the approach we are taking on capital will be a bridgehead into some things we do in the short and medium term as part of this wider agenda,' he says.

In particular, the partnership is keen to explore further opportunities around local workforce and skills initiatives, the use of local expertise in sustainability planning and local procurement and supply chain development.

On the latter, Mr O'Neill would like to see partnerships being given greater flexibility to work with both national and locally developed processes. 'Without this, how can you maximise your ambitions around economic regeneration and creating local jobs?'

Carter review

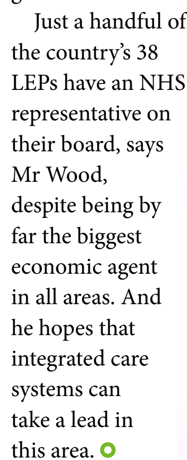
Mr Wood believes initiatives such as the Carter review of hospital productivity, which identified between £700m and £1bn of possible savings through better procurement, had the best of intentions.

'But such a national perspective is entirely cost-based – taking decisions in isolation does not help us to understand value. And many finance people would say that if they did local procurement, they did it despite the system not because of it.'

There are some high-profile leaders who back the need to buy local. Jackie Daniel, chief executive of Newcastle Hospitals NHS Foundation Trust, blogged last year about how buying more supplies from local businesses and being an exemplar employer would contribute to the health, wealth and wellbeing of the local population.

And Mr Wood cites reports of the NHS demand for personal protective clothing almost reinvigorating the Yorkshire textile industry. 'It would be amazing if the NHS could be at the heart of that,' he says, though again the centralising nature of the government's response to Covid threatens these new partnerships.

He urges health leaders to build relationships with local enterprise partnerships (LEPs)) and mayoral combined authorities (MCAs) to find out what their local economy is capable of, discover its strengths and understand how the NHS can get involved.



Just a handful of the country's 38 LEPs have an NHS representative on their board, says Mr Wood, despite being by far the biggest economic agent in all areas. And he hopes that integrated care systems can take a lead in this area.

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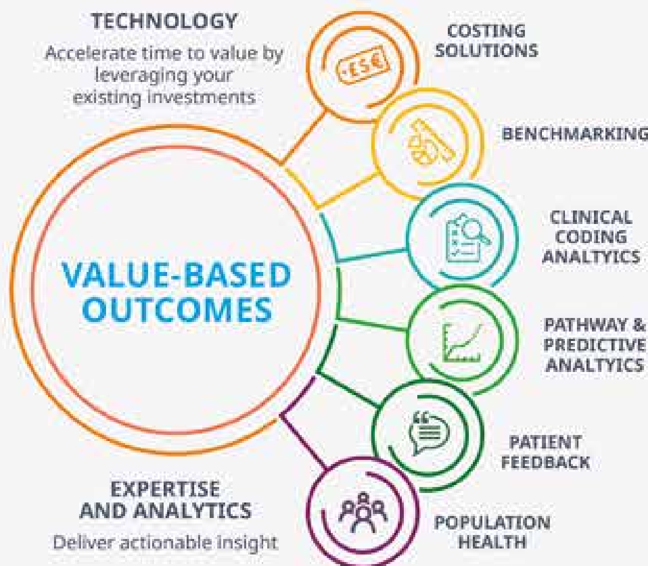

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Blending plan

Proposals for next year would mean an expanded blended payment scheme replacing this year's block contracts and mark a step away from activity-based payment. Steve Brown reports

Proposed changes to the way hospital and community services are paid for from next year would move the NHS towards the *NHS long-term plan* target of delivering population-based funding, NHS England and NHS Improvement have said. However, decisions still need to be taken about how key aspects of the system would work.

The central bodies, which are currently responsible for setting the national tariff, briefed interested stakeholders on the proposals in a series of workshops spread over two weeks at the end of October.

They stressed that they are committed to co-production of the new payment system – the initial proposals were developed with input from the NHS, even before they ran the 20 workshops attended by close to 1,000 people, including finance and contracts managers. And the proposals are not fixed, they said.

'The engagement exercise was not about briefing people on firm plans, it was about getting feedback to help us shape the proposed system,' says Gary Andrews, head of payment policy at NHS England and NHS Improvement. 'Our challenge has been to develop a payment system that people actively want to use, rather than one that they are required to adopt.'

Final proposals will be published as part of the statutory consultation at the end of December or early January, with the new arrangements taking effect from April.

Early reactions from the 1,000 or so finance and contract managers in the various workshops were mixed, ranging from people welcoming the simplification compared with the old payment by results payment approach to those who thought the proposed new system was still overly complicated or left too much risk with providers.

The proposals certainly mark a significant acceleration away from activity-based payment. They would see a blended payment approach adopted for almost all secondary healthcare services, both acute and non-acute, including community, mental health and ambulance services.

Blended payment was set as the default mechanism for emergency care and adult mental health services in 2019/20 and there had been plans to broaden the scope to include outpatients and maternity services in 2020/21. However, the expansion was put on hold as a result of the Covid-19 pandemic and the introduction of block contracting arrangements for the current year.

NHS England and NHS Improvement have indicated that they do not want to return to this phased approach to introducing blended payments. Having broken the link with activity-based payment as a result of the Covid response, returning to a system where some services remained on national tariff would be seen as a backwards step.

Lee Rowlands, contracts director at Manchester University NHS Foundation Trust and chair of the HFMA Payment Systems and Specialised Commissioning Committee, says it would also not have been practical.

'It is hard to see how we could have returned fully to any form of activity-based payment system,' he said. 'Everything is so up in the air – are we going back to normal methods of delivering activity or even to pre-Covid levels of activity? Are the tariffs, as previously calculated, actually usable? With fixed costs, if you are only getting through 75% of activity post-Covid, then the tariffs are already 25% short before you start.'

The proposals, he suggests, provide something that people can implement without

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leaving everything down to local discussion and implementation.

However, he says the work that would be needed to agree contracts and the level of detail required in risk share arrangements may vary depending on existing local relationships and the level of system maturity.

When it was first introduced, blended payment involved a fixed payment that was supplemented by variable, quality and risk sharing elements.

For example, for emergency care, the default mechanism suggested a fixed payment based on planned activity at national tariff price. There was then effectively a marginal rate of 20% paid for additional activity above plan – although this was actually calculated as 20% of the difference between actual activity at tariff minus the fixed payment.

Local framework

But as well as expanding the scope, under the new proposals, the basic framework would also be altered. Rather than setting the fixed payment using activity and tariff prices, it would be based on the locally calculated costs of delivering the activity indicated in a local area's integrated care system plan.

The proposals discussed at the workshops mean blended payment would be used for any contract value more than £10m. Below a lower threshold – covering non-contract activity and initially suggested as £200,000 – providers would be paid by their host commissioner, with adjustments made to clinical commissioning group allocations.

Between these two values, local health economies would be free to choose the most appropriate payment approach for them.

There would be no threshold for NHS England specialised commissioning activity, with all contracts covered by blended payment.

A variable element would be included, although this would specifically be for elective activity, initially focused on supporting recovery and the reduction of waiting lists during the year.

The risk share element in the original blended payment design would be replaced by a system collaboration and financial management agreement (SCFMA), which all organisations in a system would be expected to sign. This agreement, which should have been in place this year under the pre-Covid contracting guidance, would set out how financial risk will be shared across the system, commit all bodies to open book accounting and describe how a consensus view of finance will be reached.

In reality, basing the fixed payment immediately on locally agreed costs is probably more of an ambition – there simply isn't a comprehensive set of robust cost data covering all local bodies in a system. A more realistic starting point may well be rolling forward existing contract values, adjusted for inflation, efficiency and planned service developments.

Mr Andrews says this could be the 2020/21 full-year contract value or based on the second half of the year, whichever the system decides is its best starting point and the most reflective of local costs for the year ahead.

It is perhaps agreeing how risk will be shared that presents the most difficult part of the proposed new arrangements. 'It is likely to be most successful where system leadership and behaviours are strongest,' says Mr Andrews. 'Where relationships are more confrontational, it will be more difficult.'

Depending on where systems fit on this spectrum, risk share arrangements could range from loose agreements to address overspends as they arise in the year to setting out exactly how different scenarios will be dealt with.

Alastair Brett, NHS England and NHS Improvement's senior engagement manager, says the intention is to provide a payment approach that gives organisations and systems more flexibility to innovate, to move away from the previous detail around paying for inputs and to encourage discussion about the allocation of system resources.

'We want to remove barriers to innovation,' he says. 'Payment by results was sometimes seen as a straitjacket where finance was tied to the delivery of activity in a certain way.'

Blended payments should enable systems to more easily create and pay for alternative pathways. 'If you want to spend more in the community, it is easier under blended payment than going through the tariff variation process to take money out of unit prices,' says Mr Brett.

The devil may well be in the detail and participants at the workshops were keen to discuss plans for the variable payment, how high-cost drugs would be treated and what the proposals meant for existing quality incentives such as Commissioning for Quality and Innovation (CQUIN) and best practice tariffs.

Workshop participants appeared to view the proposal for non-contract activity as sensible, although there were calls to raise the lower threshold to at least £500,000.

This work is being taken forward by NHS England and NHS Improvement's standard contract team, with a separate consultation now under way (*see page 39*). But the feedback has been passed on.

The national bodies have not proposed a specific approach for setting the variable rate for elective activity above the level included in system plans and were keen to hear views. Mr Rowlands prefers the idea of working within a framework.

'My observation with leaving variable rates for wholly local discussion and agreement would be that this could take up a lot of negotiation/discussion time to agree,' he says. 'There is also a link to the impact of Covid on the costs of delivery. Without taking this into account, it could be punitive to have

Other proposals for 2021/22

- National tariff prices will still be published, with the prices set by rolling forward values from 2020/21, adjusted for efficiency and inflation.
- The prices would not be mandatory, apart from for diagnostic imaging. This would help support an increase in diagnostic imaging activity, waiting times for which have grown during the Covid pandemic, while also meeting legal requirements to publish some national prices.
- Very high-cost drugs, where there is volatility in terms of uptake, would continue to be funded on a cost and volume basis. Funding for other non-volatile specialised drugs would be rolled into the fixed payment.
- The service would move to the third step of the five-step market forces factor glidepath.
- The top-slice to cover overhead costs of Supply Chain Co-ordination is likely to be held at the current level.

"We want to remove barriers to innovation. Payment by results was sometimes seen as a straitjacket where finance was tied to the delivery of activity in a certain way"
Alastair Brett, NHS England and NHS Improvement

marginal rates using tariffs that no longer work or fit with post-Covid costs of delivery.'

Proposals to retain additional quality incentive payments were seen as incongruous by some, given that the vast majority of activity would be covered by a single fixed payment.

The fact that these schemes attract additional payment might distort priorities, and setting the CQUIN reward at just 1.25% might mean some providers decide the benefits do not justify the extra costs involved.

Similarly, the current thinking is that best practice tariffs would become non-mandatory. The previous year's level of achievement could be reflected in the fixed payment and then this would be adjusted in light of actual delivery.

Some practitioners felt that the tariffs, which reward patient-specific responses in selected pathways, were out of step with the overall approach.

Mr Brett says clinicians remain keen to retain the ability to signal that these areas are important. However, NHS England and NHS Improvement acknowledge there is a tension between the macro-level approach of blended payment – which provides an overall sum of money and allows systems to decide

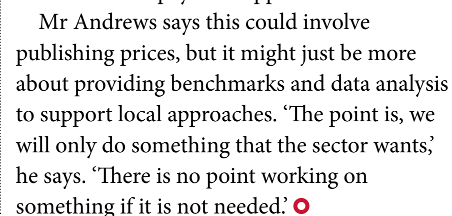
"Our challenge has been to develop a payment system that people actively want to use, rather than one that they are required to adopt"
Gary Andrews, NHS England and NHS Improvement

the best way to meet patient demands – and retaining micro-level controls for specific treatments and patients.

Practitioners suggested that the use of quality incentives should be considered alongside a wider review of the use of contract sanctions.

The national bodies are clear that the proposals for next year are part of a transition to population-based funding as required by the *NHS long-term plan*. The aim for subsequent years after 2021/22 would be to improve the cost-reflectiveness of blended payment, leaning more on local patient-level costing data to set the fixed payment rather than rolling forward existing contract values.

Beyond that, further refinements could be introduced, such as pathway or year of care-based payments for specific cohorts of patients, so that various payment approaches are in use.



Mr Andrews says this could involve publishing prices, but it might just be more about providing benchmarks and data analysis to support local approaches. 'The point is, we will only do something that the sector wants,' he says. 'There is no point working on something if it is not needed.'

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costing questions

The case for patient-level costing remains strong, but can the service really move to quarterly reporting? And is the costing methodology simply too complex? Steve Brown reports

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Policy and financial changes in the NHS mean the case for costing at the patient level is stronger than ever and there are increasing pressures for granular information to be produced on a more regular basis.

This was one of the key messages from NHS England and NHS Improvement director of pricing and costing Chris Walters when he addressed the annual HFMA Healthcare Costing for Value Institute costing conference in November. The conference was postponed from its normal timing in April because of the Covid-19 pandemic.

The pandemic has created challenges for costing practitioners and for the Costing Transformation Programme. Questions remain over the usefulness of nationally submitted costing data produced for 2020/21 (and submitted next year) because of the severe disruption to services.

But Mr Walters said the need for detailed, reliable cost data was inarguable. 'My priorities for costing are framed by what it means to meet the commitments of the *NHS long-term plan*,' he said. 'That means two things. The first is supporting the many commitments – some clinical, some operational and some financial – that rely on reducing unwarranted variation across the NHS.

'It also means supporting the three commitments for reform of the payment system – namely, to take better account of the cost of delivering efficient services locally, to move funding away from activity-based payment and to move to a blended payment model. It is self-evident how important patient-level costing is to both.'

Mr Walters added that future changes to legislation and the financial landscape would also create a greater reliance on patient-level cost data.

In particular, he highlighted the accelerated move to blended payment (*see Blending plan, page 30*) and moves towards system working. System working would be 'mainstreamed' in the next few years, he said, building on collaboration during the Covid-19 response.

'Successful system working relies on integrated care systems having a common and shared understanding of system cost and value,' he said. 'Continuing to expand the reach of patient-level costing and improve the quality of information it provides will be essential to this on the provider side, as will rebooting our work on programme budgeting on the commissioner side.'

The plans for using blended payments suggest that payments should be based on the local costs of delivering activity in system plans. For most areas initially, the best estimate of local costs will be this year's contract value. But over time the proposals envisage a greater level of cost-reflectiveness, which will rely heavily on robust local cost data.

And as competition is replaced by collaboration, systems will look to patient-level cost data to analyse and redesign healthcare pathways that run across organisational boundaries.

'All three developments should present us with even more of a platform to showcase the undoubted benefits of value-added costing,' said Mr Walters.

> "Moving to submitting and collecting patient-level costs on a quarterly basis is realistic and something we should aspire to"
> Chris Walters, NHS Improvement

There are already significant challenges for costing practitioners in meeting the demands of the Costing Transformation Programme, which sees mental health and ambulance service trusts join acute trusts in making a mandatory patient-level submission for 2019/20 costs.

There are concerns among finance practitioners that the workload required to meet prescriptive and detailed costing standards and specific collection criteria leaves little time to actually use the cost data to drive improvement with clinical teams.

Despite this, Mr Walters said that more regular submissions were likely to be required in future. 'The pandemic has thrown up an additional future priority – the need to collect patient-level costs more frequently and with less of a delay than at present,' he said.

The daily briefings from 10 Downing Street during the pandemic – with daily updates on new Covid cases, admissions and deaths – had raised expectations among the public and politicians, he added. 'As the costing community, we must be prepared to respond.'

Mr Walters told the conference 'Knowing activity, casemix and patient-level costs on a daily or weekly basis won't be possible for a very long time, if ever. But moving to submitting and collecting patient-level costs on a quarterly basis is realistic and something we should aspire to.'

Exceptional collection

A number of acute providers have already volunteered for an exceptional quarterly collection (EQC) this year, specifically aimed at understanding the costs of delivering care to Covid patients and the impact the pandemic has had on costs of non-Covid patients. This has been based on reference cost-style average cost collections, rather than patient-level costs and will continue with volunteer organisations for the rest of financial year.

Mandating a quarterly National Cost Collection (NCC) based on patient-level costs would move things to a completely different scale. It is understood that this would need to go through a mandation process involving an impact assessment and consultation. However, discovery and scoping work will begin in January.

Mr Walters said that understanding how this could avoid increasing the burden on costing teams would be an important part of the work.

This will be key to keeping costing practitioners on side. Many practitioners spoken to by *Healthcare Finance* see the national costing approach as too detailed. They want the focus put firmly on providers' major costs by raising the level of materiality below which detailed costing data is not required.

Last year, the HFMA called for the approach to be streamlined, so that the resources needed to produce the cost data are more proportionate to the benefits. As part of this, it believes the resource/activity matrix that needs to be compiled for each individual patient should be reduced. Practitioners point out that while costs have to be broken down into hundreds of resources and activities, 80% of costs might typically be covered by just 20 to 30 resource groups.

In a response to the HFMA's recommendations, NHS England and NHS Improvement said the 2020 standards reduced the number of resources required, though collection resources (the smaller number of resource categories that must be submitted as part of the cost collection) were increased. While some activities have also been reduced, there will be further rationalisation this year.

The central costing bodies have also retained the requirement to map the general ledger to a cost ledger as the first step in the costing process. Some practitioners claim there is little value in the exercise other than forcing organisations to look at their general ledger in more detail. And some costing software does not support the cost ledger function. In response to these concerns, a two-level mapping approach was introduced this year, allowing trusts to map directly to collection resources.

Practitioners remain concerned about the time taken to submit costs centrally compared with the time this leaves to support their organisations to use patient-level cost data to drive improvement. The move to a quarterly patient-level cost collection would exacerbate this.

'The danger is that we would spend the whole year producing information for the national collection, rather than supporting clinicians and service managers to use the data,' says Chris Marshall, costing manager at the Royal Marsden NHS Foundation Trust. 'And it would exacerbate problems with recruitment and retention.'

There has long been a recognition that the move to patient-level costing would require an expansion of costing teams. However, this hasn't materialised and costing practitioners insist that it is using costing data that makes the job attractive, rather than the nuts and bolts of deriving robust cost data. 'And using the data is the best way to improve the quality of the data,' adds Mr Marshall.

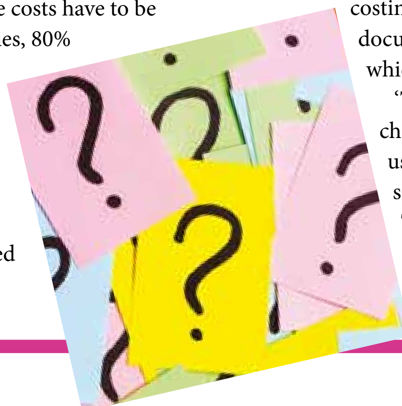
It is not the frequency of collection per se that would be the problem. Many trusts already report their own patient-level cost data on a quarterly basis, some even monthly. In fact, this is the data they use internally to support improvement work, not the national cost data, which is collected after the year-end and is not played back to providers for several months.

Many acknowledge that the national costing standards have helped to improve their costing processes and provide a common approach that makes data more comparable.

But there are key differences between the data generated and used locally and that required by the centre, with the National Cost Collection wanting certain costs excluded and far greater levels of detail.

So while one trust might be able to identify the pathology costs in a patient episode, under the National Cost Collection process you would be able to see how this pathology cost was made up of consultant and clinical time as well as consumables and other costs. The process around unbundling services such as chemotherapy, radiology, direct access and diagnostic imaging is one of the key differences between national and local approaches.

One of the big challenges is simply keeping on top of the guidance. The old reference cost guidance was at one time a booklet of between 100 and 150 pages. The guidance for acute trusts is now volumes one, two, three and seven of the collection guidance, separate standards for information requirements, costing methods and costing processes, an extract document and technical document – not to mention staying on top of FAQs, which override the guidance.



'There is some good stuff in there that internally has changed and pushed the way we do our business-as-usual patient-level costs, which we produce monthly,' says Dave Tunstall, senior costing accountant at The Leeds Teaching Hospitals NHS Trust. 'But the volume of material is an issue. It not only takes a long time to work through, but it can

also be difficult to find what is relevant. Especially when there are inconsistencies between volumes, which mean you end up having to contact NHS England and NHS Improvement and keep checking the FAQs for the latest clarifications and corrections.'

So quarterly patient-level cost submissions would not be as simple as hitting a computer key each quarter and producing a data file for NHS England and NHS Improvement.

Practitioners, accustomed to regular local reporting, say that the first three months of the financial year can be taken up with the national submission. To move the quarterly patient-level cost submission idea forward, some practitioners suggest it would need to become more of a simple local system output, perhaps with new resource/activity codes enabling NHS England and NHS Improvement to exclude unwanted costs centrally.

Covid challenges

The Covid-19 outbreak created challenges for the 2019/20 submission. Some practitioners were redeployed to other duties as part of the NHS response to the first wave. And typically they didn't have the usual access to service managers and clinicians to validate data.

But Mr Walters said that a week before the mid-November deadline for acute and community providers, submissions were 'right on track', including dry-run submissions from mental health providers. The window for submissions for ambulance, mental health and IAPT (improving access to psychological therapies) costs opens in January.

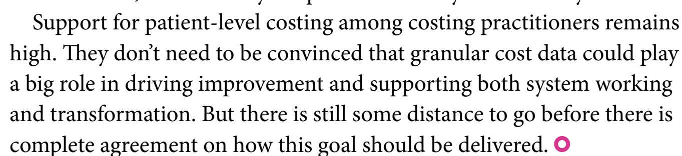
Looking ahead, 2020/21 is likely to be far more challenging, and perhaps the biggest problem will be understanding exactly what staff did and where they did it, such was the level of redeployment. Consultants and other clinical staff changed routines and rotas to support the frontline effort. But changes in how staff were used during Covid has not been properly captured in activity systems.

There are lots of other issues too. Trusts leant heavily on private hospitals during the outbreak. In some cases, this was centrally funded and the private providers undertook all the care, while in other cases NHS consultants would simply be using these private facilities – leading to under-reporting of costs for this activity.

In the 2019/20 collection, exceptional Covid costs – those reported to NHS England and NHS Improvement and remunerated via a top-up process – were excluded from the cost quantum. If this approach is taken again for 2020/21, then this will lead to an under-reporting of costs for some patient episodes.

A number of practitioners are struggling to see what the 2020/21 data could be used for. It wouldn't be comparable to other years and it would be difficult to see how it could be used to inform tariffs, whether they are produced locally or nationally.

Support for patient-level costing among costing practitioners remains high. They don't need to be convinced that granular cost data could play a big role in driving improvement and supporting both system working and transformation. But there is still some distance to go before there is complete agreement on how this goal should be delivered.



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hfma
professional lives

Events, people and support for finance practitioners

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Valuations and provisions highlighted as priority areas for 2020/21 year-end

Technical

It seems a little early to start thinking about the end of the financial year, but 2020/21 has been a year like no other, so there may well be more to think about, *writes Debbie Paterson*.

In terms of financial reporting requirements, 2020/21 is a straightforward year, now that the IFRS 16 leasing standard has been deferred.

There are few changes to accounting standards and NHS bodies are likely to be affected by only one of them. It is the change to the definition of material in international accounting standards IASs 1 (*Presentation of financial statements*) and 8 (*Accounting policies, changes in accounting estimates and errors*). Information is considered material 'if omitting, mis-stating or obscuring it could reasonably be expected to influence decisions …'.

The reference to obscuring data is new – information should not be inappropriately aggregated or hidden in lots of immaterial information to make it less obvious. The other new reference is the inclusion of a reasonability test when thinking about whether information will influence decision-making. This amendment to the standards is unlikely to have a big impact on the preparation of NHS accounts, but will need to be considered when determining materiality and reviewing the statements.

It is likely that judgements and estimates will be difficult this year. In its year-end letter, the Financial Reporting Council (FRC) makes it clear that the backdrop of Brexit and Covid-19 is a high level of economic uncertainty: 'Where judgements have been made involving significant estimation uncertainty, we expect to see increased disclosure of relevant sensitivities or ranges of possible outcomes to help users of the accounts understand the assumptions made and the extent of the changes that might be reasonably possible in the next 12 months.'

SHUTTERSTOCK

In its report *Developments in audit 2020*, the FRC has also identified that two of the most common areas for audit improvement are sufficient challenge of management and the audit of going concern. Both involve management making judgements and estimates, so this is likely to be an area of interest to auditors.

The uncertainties in 2020/21 mean that judgements and estimates will be harder to make. Relying on the previous year or even past experience as a basis for decisions is not going to be possible. The areas that are worth thinking about early are valuations and provisions.

At the end of 2019/20, most valuers included a statement about the fundamental uncertainty in their valuation as a result of Covid-19 and this was referred to by some auditors in their reports.

It is looking less and less likely that this will change by the end of this financial year. It may be worth having early discussions with valuers and auditors about this.

Where NHS bodies are considering the valuation of their specialised assets on a modern equivalent asset basis, the impact of Covid-19 on what a modern equivalent asset would look like should be considered. Often when considering a hypothetical new build, a judgement is made that it would have a smaller footprint, but may have more floors than the existing estate. In a world where social distancing and one-way systems are the norm, is this still the case? Do those judgements need to be revisited?

In relation to provisions, holiday pay accruals will be different this year. Staff have been unable to take all of their holiday this year, and the amount of untaken leave that can be carried forward from one leave year to another has been increased. Those bodies that have not usually included a holiday pay provision in their accounts on the basis of materiality may need to revisit that assumption.

The *Restriction of Public Sector Exit Payments Regulations 2020* came into force on 4 November, introducing a £95,000 cap on exit packages from that date. So, provisions for exit payments will need to be reviewed as a result.

Finally, stock/inventory is likely to be different in 2020/21. The levels of personal protective equipment (PPE) held in stock will probably be higher than in previous years, which may mean stock becomes material for some NHS bodies.

Some of the stock, particularly of PPE, may not have been purchased by the organisation that is storing it, so agreement needs to be reached as to whose accounts it will sit in.

In 2019/20 some NHS bodies received qualified audit opinions as auditors were unable to attend stock-takes during March 2020. It would therefore be sensible for management to review the arrangements that are currently in place to satisfy themselves that stock is appropriately recorded in the accounts, so that they can implement alternative procedures early in 2021 if necessary.

Debbie Paterson is HFMA policy and technical manager

Technical review

Technical

The introduction of the international financial reporting standard on leasing – **IFRS 16** – has been deferred for the Department of Health and Social Care and the NHS until 1 April 2022. The standard was originally published in 2015 and adopted by companies (including NHS companies and community health partnerships) in 2019/20. The NHS was due to adopt the standard from April 2020, but this was deferred earlier this year in the face of the Covid-19 pandemic to reduce the burden around the year-end. Given the service now faces a challenging winter as it meets the second wave of the virus – this time running more non-Covid services in parallel – the requirement for compliance with the standard has now been deferred a further year. NHS England and NHS Improvement requested the additional delay to recognise the pressures facing the NHS and finance teams and the Treasury and the Financial Reporting Advisory Board have both agreed. At the end of November, the Treasury was still to decide what this meant for the wider public sector in terms of implementation dates. Application guidance for the standard was published by the Treasury in December 2019.

The HFMA last month welcomed plans to reform the **VAT refund system** but said it would need careful planning and implementation. In particular, the association warned that the aim for the changes to be fiscally neutral should also apply at other levels in the system. Alternatively, the impact of the change on an individual body's financial position would need to be recognised as outside its control, the HFMA said. NHS bodies cannot currently recover VAT incurred delivering most non-business activities, which includes the delivery of healthcare. However, they can recover VAT on a limited list of services, covered by section 41 of the *VAT Act 1994*. The Treasury recognises that the current system is overly complex and not fit for purpose and proposes the adoption of a full refund model. VAT would be recoverable on all goods and services used in non-business activities and the Department of Health and Social Care's expenditure limit would be reduced to reflect this reduction in cost. The HFMA response also highlighted the importance of timing, with managers needing at least one planning round to implement the changes. hfma.to/dec201

Audit Wales has published the 2020 version of the ***Code of audit practice***. The document, which replaces the 2018 version, takes account of changes in terminology that have occurred since the previous code was published. It reflects the commitment the auditor general made to the Senedd's finance committee to consider annually whether to update the code. None of the changes made to the code are considered substantive, meaning the code did not require further consultation. hfma.to/dec202

A new briefing from the HFMA – *Non-statutory and hosted bodies: accounting and governance issues* – explores the considerations finance teams need to make when determining the financial structures to use for **non-statutory entities**. With the move to system working, local health economies are increasingly working in a joined-up fashion. However, while these partnership entities require financial information and financial reports to support management, they have no statutory basis and cannot enter into financial transactions themselves. The briefing looks at the use of hosting arrangements, such as those adopted for the Nightingale hospitals, and a consolidation approach. This involves each entity accounting for its own transactions, with a consolidated statement then produced for management purposes. A blended approach may also be used in some cases. The briefing considers the governance implications and common accounting policies. hfma.to/dec203

In October, HMRC provided an update on recent litigation on the **VAT treatment of car leasing schemes** using salary sacrifice arrangements. The update followed the Court of Appeal ruling that an NHS trust was entitled to claim a refund of VAT incurred. The court confirmed that the provision of cars to employees under salary sacrifice arrangements did not amount to economic activity, so VAT could be reclaimed. HMRC has accepted the decision and the litigation has concluded. hfma.to/dec204

Significant changes could be made to the arrangements for contracting and paying for low-volume flows of activity between clinical commissioning groups and providers from April next year, under proposals put forward by NHS England and NHS Improvement at the end of November. The changes, which will largely affect **non-contract activity** (NCA), would embed the short-term simplification introduced for 2020/21 in response to the Covid pandemic. Under previous arrangements, invoices with a value of less than £10,000 have accounted for 82% of total trust-to-CCG invoices by number, but only 1% by total value. Instead, trusts would build invoicing for NCA into existing contractual arrangements with their co-ordinating commissioner – reducing the number of invoices by around 340,000 in a full year. hfma.to/dec206

Qualification successes during a challenging year

By Alison Myles, HFMA director of education

Training

A virtual awards ceremony at the start of December will celebrate the latest successful graduates from the HFMA Academy's increasingly established portfolio of qualifications.

A total of 55 diplomas, certificates and awards will be 'handed' out at the ceremony, held as part of the student day on Friday 4 December in this year's HFMA annual conference, running online over the first two weeks of the month.

To date, 578 students have embarked on qualifications with the HFMA Academy. And nearly 20 people have gone on to start a final year of study, which leads to an MBA in Healthcare Finance, delivered by BPP University.

It is fantastic to see so many people doing well. These are demanding qualifications with an 85% pass rate and the feedback from students is consistently high. 'I love, it, love it, love it' was the response from one student on our primary care management diploma, claiming they could already see their improved personal effectiveness.

A student on our masters-level healthcare business and finance diploma rated the content of the costing module as 'excellent' and 'engaging'. Students often praise tutors, many of them former finance directors – 'fantastic', 'brilliant', 'incredibly knowledgeable', 'interested in their field', 'the highlight', and 'approachable' have been among the comments.

Among those 55 awards will be 30 Advanced Diplomas in Healthcare Business and Finance – 16 at the higher level, enabling the graduates to move on to the final year of the MBA, if they choose. We are also handing out five advanced certificates, gained by taking a single module from the advanced diploma curriculum, and seven intermediate awards for completing a module from our level 4 diploma.

The HFMA has been involved with the Diploma in Advanced Primary Care Management since it was piloted in 2016, but we have now taken on full responsibility for managing and assessing the programme. And 13 diplomas represent our first awards since assuming this wider role. With a further 23 students having just embarked on the programme, the qualification continues to attract those with a role in primary care, including many practice managers.

It has been a tough year for everybody, the NHS and care sectors particularly. But our students have faced challenges of their own. Homeworking, redeployment to other roles and working in a rapidly introduced temporary financial framework have all created pressures.

A number of students have commented about how these have all added to the stress of studying, with some understandably deciding to defer assessment. The qualifications can place big demands on students. But we think they are worth the effort. From their feedback, our successful graduates seem to agree.

We look forward to celebrating with them at the conference – albeit virtually this year.

• **Visit www.hfma.org.uk/qualifications/**

Bitesize milestone

More than 11,500 free HFMA bitesize courses have been accessed since their launch in April 2020, enabling learners to clock up 79,103 hours of continuing professional development.

It is just a year since the full bitesize portfolio was launched, with the free content made available to the NHS at the start of this financial year. Bitesize courses come in three formats – short (three hours), intermediate (six hours) and advanced (10 hours) online options.

There are 95 courses covering a wide range of topics, including an introduction to NHS finance, how providers are paid, business cases, budgeting and capital, as well personal development issues such as managing conflict and managing teams.

Five new courses, on management skills, launch on 4 December. So a total of 28 courses are now freely available to anyone working in the NHS – delivered via the Electronic Staff Record or an organisation's own learning management system.

Inclusion and diversity guidance launched

Future focused finance

Future-Focused Finance has produced a new inclusion and diversity resource pack with its national inclusion and diversity delivery group. The pack includes practical steps that individuals and teams can take to make improvements to the working culture, diversity, and inclusivity of their finance departments. It includes step-by-step guidance and real-life examples from NHS organisations across the country.

The document has four categories:

- Creating a diverse workforce
- Maintaining an inclusive environment
- Demonstrating inclusive leadership
- Training and development ideas.

The document includes an abundance of actions that colleagues working at all levels in finance can take forward. With links to the FFF Towards Excellence accreditation process, the document should make it easier for teams to work through the inclusion and diversity focused items in all three levels of the accreditation, while bringing colleagues together in an engaging and rewarding way.

Edward John (pictured), director of operational finance at Frimley Health NHS Foundation Trust, and FFF programme lead for inclusion and diversity, says in the foreword: 'Hopefully, we have provided you with a catalyst for a conversation in your teams that will yield real positive action.

It is really important to kick start conversations and to provide a safe place for those conversations to happen in an open and honest way. Addressing cultural challenges in the workplace can be a heavy subject to tackle, so encourage humour and enjoyment throughout the process, which will have rewarding and powerful outcomes.'

• **Download the resource pack using the weblink bit.ly/332oeAX**

Diary

November/December

30-11 Ⓝ HFMA annual conference
14 Ⓑ London: you and the new normal, online
15 Ⓑ London: advanced influencing and negotiating, online

January

8 Ⓝ Primary care and the long-term plan, online
13 Ⓑ Eastern: introduction to NHS finance, online
14 Ⓑ London: developing an integrated care system, online
19 Ⓗ Chief finance officer and directors' forum, online
20 Ⓘ Introduction to costing in the NHS, online
20 Ⓑ Eastern: understanding pensions and HMRC allowances, online
21 Ⓑ South Central, South West, South West and West Midlands SDNs: developing talent conference, online
22 Ⓑ London: how to thrive and maintain your mojo, online
27 Ⓗ Chair's conference, online

February

3 Ⓝ Pre-accounts planning, online
4 Ⓑ London: systems and leadership, online
10 Ⓗ Finance managers forum, online
11 Ⓗ NHS leadership and CEO network: forum
24 Ⓗ Integrated care summit, online
25 Ⓘ Costing together, online

March

2 Ⓗ Commissioning network: technical forum, online
3 Ⓑ London: building high performance teams, online
4 Ⓗ Audit conference, London
10 Ⓗ Mental health conference, London
11 Ⓘ Institute symposium, online

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

key Ⓑ Branch Ⓝ National Ⓘ Institute Ⓗ Hub Ⓦ Webinar

Branch contacts

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

Events in focus

Pre-accounts planning
3 February, online

The ever-popular annual HFMA pre-accounts planning conference returns in February as an online event. Only one event will be run this year, due to the impact of Covid-19.

This is a must-attend event for those involved in the planning and delivery of the 2020/21 annual accounts, with Covid potentially affecting the accounts process, as it did for the 2019/20 accounts. There will be a mix of plenary and workshop sessions, providing an opportunity for discussion, networking and for practitioners to feed back information and questions to colleagues from NHS England, NHS Improvement and the Department of Health and Social Care. Issues that are likely to arise from the 2020/21 accounts preparation and audit process will be raised and debated at the event, which is CPD-accredited.

• **To find out more or to book your place, email** josie.baskerville@hfma.org.uk

Integrated care summit
24 February, online

Although health and social care bodies were striving to integrate their services prior to the Covid-19 outbreak, many areas witnessed a step change in collaboration with the divisions between organisations melting away as they responded to the pandemic.

The government has also backed system working – both during the pandemic by linking payments to activity at system level, for example, and by restating its intention to ensure all areas of England have an integrated care system at the beginning of the 2021/22 financial year.

Against this backdrop, the HFMA is holding this one-day virtual event that will gather all sectors of the NHS and local government.

The event brings together the HFMA system finance, provider, commissioning and mental health networks, and partners can bring a local authority colleague to this year's summit for free.

There will be opportunities to discuss priorities and challenges within each sector, and there will be case studies highlighting examples of successful integrated working that are delivering improved outcomes for patients and clients.

• **For more details or to register your interest, email** josie.baskerville@hfma.org.uk

An extraordinary year

Association view from Mark Knight, HFMA chief executive

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

My HFMA

It's that time of year again as we approach the HFMA annual conference. But instead of the physical conference this year, we have the '12 days of conference' – an online festival of learning.

As I write ahead of the event, more than 150 organisations and 3,000 delegates are registered, easily eclipsing our record attendance of 777 in 2014. It is a real demonstration of the spirit in the NHS finance function, because not only will it be a substantial commitment to continuing professional development, but it shows solid support for the association. Thank you to all who have made the decision to be at the event and to all our commercial friends, who are sponsoring sessions and taking part in the exhibition.

While we won't be together in the same room, it is a powerful thing to be able to enable so many people to take part. It makes me wonder about how that will affect professional development going forward.

Some aspects of the pandemic have been truly upsetting – relatives not able to be with dying loved ones, millions not seeing their families. For us, in our world, not going to branch and national conferences has meant we are unable to meet colleagues in sister organisations. You miss those little corners where you can pass on information and share intelligence. It's the same with not attending the office regularly – you miss those moments of chemistry between colleagues.

But it hasn't been all bad. While I don't feel I'm leading an organisation some days because I'm on Teams in my front room, I have also benefited from not travelling so much and having the flexibility that being at home offers.

This suggests long-term benefits to some of the responses we have made to Covid. Why not offer more streaming opportunities to our events? In the past, we've not looked at that much because we've worried about attendance. But I think the sheer numbers we have reached this year suggest there's a place for both.

We know that, when given the opportunity, many will still want to travel to events just for the enhanced benefits of being together. On that basis, we're looking at building more streaming facilities at 110 Rochester Row, as that fully reopens in the new year. And we are exploring investments in equipment and training in using cameras to live-stream out. This will enable us to adapt our business model in a post-Covid world.

HFMA chief executive Mark Knight

We will also be looking into how our whole offering and services move forward over a range of areas. We hope that in the first months of 2021 we will see a substantial part of the vulnerable population vaccinated, and that this will lead to a near return to normal life.

For the association, in common with lots of different services, I get the feeling that things will change for us forever. We will be delighted to see the end of constraints on our freedoms, but we will be looking to retain those aspects that have worked well.

I'd like to thank everyone who has enabled the HFMA to move forward in this year, be they staff, volunteers or supporters. Without this team effort, we couldn't have achieved what we have done. I'm looking forward to the virtual conference. It's a monster, running over 12 days. And we will do our very best to round off what has been an extraordinary year.

Member news

Kent, Surrey and Sussex Branch has made several announcements. Jamie Bewick, Sussex Community NHS FT, has joined its committee; it has raised £1,040 for Porchlight, the Kent charity for homeless or vulnerable people; and it has presented its annual awards:

- Student of the Year: Melisha Chhantyal
- Finance Team: Kent Community Health NHS FT
- Outstanding Contribution: Stuart Doyle, Maidstone and Tunbridge Wells NHST
- Overcoming Adversity: Western Sussex Hospitals NHS FT financial reporting and compliance/financial services teams (pictured).

The **South Central Branch** has also presented a number of awards at its annual conference:

- Deputy Director of Finance: Mike Clements, Royal Berkshire NHS FT
- Pride in our NHS: Martin Harris, Oxford University Hospitals NHS FT
- Training and Skills Development (joint winners): Edward John, Frimley Health NHS FT and FSD Working Group, University Hospital Southampton NHS FT
- Finance Team: Oxford University Hospitals NHS FT

The **West Midlands Branch** has raised £183 for Aquarius, a local charity supporting adults and children with addiction issues, and their families.

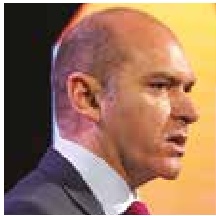
Zak Hussain, head of finance at King's College Hospital NHS Foundation Trust, has joined the **London Branch** committee.

HFMA trustee and South Warwickshire NHS Foundation Trust finance director Kim Li was recently shortlisted by the *Health Service Journal* for a list of the most influential BAME people in healthcare. In addition, HFMA member Tim Kelland, NHS Wales Finance Delivery Unit assistant director, has been named ACCA UK Advocate of the Year 2020.

Member benefits

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

Appointments



In an additional role, **James Mackey** (pictured), chief executive of Northumbria Healthcare NHS Foundation Trust, has been appointed chair of the NHS Customer Board for Procurement and Supply, NHS Supply Chain has announced. The board aims to influence and lead procurement strategy by engaging with the senior stakeholders who understand the challenges faced by the NHS. It has a particular focus on the new NHS Supply Chain operating model and oversees four regional boards, North, Midlands, South and London. Mr Mackey is due to succeed **Ian Carruthers** in 2021. Sir James, a former NHS finance director and chief executive of NHS Improvement, said: 'I am delighted to be joining the board and very keen to ensure trusts' views on procurement are reflected within the organisation's plan in order to influence the procurement landscape.'

Alex Gild (pictured), deputy chief executive and chief financial officer at Berkshire Healthcare NHS Foundation Trust, has also joined the National Procurement And Supply Board. A former HFMA president, Mr Gild, who remains in post at the Berkshire trust, has in addition been named as the new chair of NHS Supply Chain's South Customer Board.

The Sussex health and care system has appointed **Carla Moody** (pictured) to the role of director of finance (Sussex commissioning). The appointment has been made by the three clinical commissioning groups in Sussex – Brighton and Hove, East Sussex, and West Sussex CCGs. Ms Moody has more than 18 years' experience in the NHS, working in audit and regulation. Most recently, she has been leading the Sussex Covid-19 project management office.

Simon Crowther has been appointed executive director of finance and performance at University Hospitals of Derby and Burton NHS Foundation Trust. Mr Crowther, who is also an HFMA trustee, has joined the trust from Nottinghamshire Healthcare NHS Foundation Trust, where he held the role of executive director of finance, information and estates from 2015. He succeeds **Kevin Downs**, who has retired.

Nottinghamshire Healthcare NHS Foundation Trust has appointed **Lorraine Hooper** executive director of finance, information and estates to succeed **Simon Crowther**. She is due to join the trust from North Staffordshire Combined Healthcare NHS Trust, where she is director of finance, performance and estates, in the new year.

Rob Clarke (pictured) has been appointed deputy chief financial officer (strategic planning) at Barts Health NHS Trust, and is expected to take up the position this month. He is currently director – intensive support (acting)/ improvement director at NHS England and NHS Improvement, and director of finance at NHS Nightingale Hospital London.

Adcock heads to Morecambe

Chris Adcock (pictured) has been appointed director of finance at University Hospitals of Morecambe Bay NHS Foundation Trust. He is due to join the trust in February from Sussex NHS Clinical Commissioners, where he is the chief finance officer for the three Sussex clinical commissioning groups. He is also finance lead for the Sussex Health and Care Partnership Integrated Care System.

Mr Adcock has worked in the NHS for more than 20 years and prior to his current post, held chief financial officer roles in hospital trusts in Portsmouth, Staffordshire and Sussex.

He said: 'I am delighted to have been offered the opportunity to join UHMBT to work with colleagues and system partners to take forward the exciting hospital and integrated care agendas at such an important and challenging time.

'Having grown up in the North West and with family living in the area, I have spent a great deal of time around Morecambe Bay over the years and I am looking forward to relocating and having the opportunity to make a contribution to the communities served by our hospitals and health and care services.'

He will split the deputy chief executive role with executive chief nurse Sue Smith. Mr Adcock will succeed Keith Griffiths, who has joined Cheshire and Merseyside Health and Care Partnership as director of finance.

Liz Romaniak (pictured), director of finance, contracting and facilities and deputy chief executive at Bradford District Care NHS Foundation Trust, has joined Tees, Esk and Wear Valleys NHS Foundation Trust as director of finance and information. She joined the Bradford trust in 2007, initially providing foundation trust project management. She was head of financial management and deputy director of finance before being appointed finance director in 2014. She became deputy chief executive in 2017. Ms Romaniak succeeds **Patrick McGahon**, who retired in July.

University College London Hospitals NHS Foundation Trust has appointed **Tim Jaggard** deputy chief executive. He will continue as the trust's chief financial officer, and as finance lead for North Central London Integrated Care System, but in his new role he will also take on line management responsibility for corporate governance. Next year, he will take responsibility for estates and facilities and have an external focus across North Central London and with the London regional team.

Bob Chadwick, executive director of finance Cardiff and Vale University Health Board, has retired. He joined the NHS in 1992 and has been a board director for 21 years, the last five at Cardiff and Vale.

"It's about growing our own staff as part of the medium- and long-term response to workforce shortages – and partnerships with education are vital to that"
Ian Boyle, Wrightington Wigan and Leigh NHS Foundation Trust

Boyle returns to WWL

On the move

Ian Boyle has joined Wrightington Wigan and Leigh NHS Foundation Trust (WWL) as chief finance officer – a return to a trust where he has spent a large part of his working life.

Mr Boyle, who was previously Bolton Clinical Commissioning Group's chief financial officer, spent six years at WWL between 2002 and 2008, and he jumped at the chance to return.

'I really enjoyed my time here previously, and it's the longest time I've spent in one role. As soon as the job came up, I knew it was an opportunity to go back to an organisation where I could hit the ground running. Some of the faces of the directors have changed, but a lot of the senior clinicians remain the same,' he says.

He admits that joining an organisation during a pandemic is not the best timing, but in his first few weeks he has been able to have a full induction via MS Teams, including a call with the medical division 'just to say hello and get a feel for the front line of our Covid response'.

Mr Boyle succeeds Rob Forster, who is now chief finance officer and deputy chief executive of Liverpool University Hospitals NHS Foundation Trust. Bolton CCG deputy chief financial officer Kelly Knowles is now acting CFO at the commissioning body.

The WWL finance team has a proud record of winning awards, particularly the HFMA annual awards. In November, it was shortlisted for the 2020 Governance Award. 'The trust has a great reputation in terms of its finance team, and it is well regarded in the North West for best practice in a lot of areas, such as finance staff development,' Mr Boyle says.

'For me, it's about making sure we maintain those standards. We have demonstrated our ability in these awards, but it's not just about the awards night and the black ties, but how we share best practice and learning with our colleagues.'

He is chair of the HFMA North West Branch and is impressed with how the WWL finance team share learning at branch events.

One of his top priorities is to help WWL build on good relationships with Wigan Council, the Healthy Wigan Partnership – which includes the local authority, local providers, GPs and commissioners – and the primary care networks.

He believes the Healthy Wigan Partnership is the vehicle to carry the conversation on joint working and the Wigan pound.

'In Bolton, we had the concept of the Bolton pound, which could only be spent once, whether it sits with the local authority or the NHS. Those conversations have already started in Wigan, and the council and CCG are behind it. It's about how you talk about social value and how you support the local economy, spending on supplies from local businesses. It's also about growing our own staff as part of the medium- and long-term response to workforce shortages. And partnerships with education are vital to that.'

The trust has gained teaching status and Mr Boyle says the next step is to become a university foundation trust.

Covid-19 poses a challenge to every NHS organisation. But besides this, WWL, like other providers, faces uncertainty over the future of the finance regime. 'The trust has underlying financial challenges, as most foundations have, and this is where the conversation comes back to the Wigan pound and working with partners to get best value,' he says.

Workforce is linked to the financial challenge, and the trust's commercial arm is working with Health Education England to recruit international nurses to the North West.

Estates is also a big issue, and with capital in short supply, Mr Boyle feels there is an opportunity to look strategically at building utilisation with its partners.

He was the HFMA's first national student of the year in 1998, having earlier been given the North West Branch Sue Rosson Award – its annual student award. He says it was his first major interaction with the association nationally, his prize including a place on the US-UK Exchange Programme. It was also the start of a close association with the HFMA, which has continued throughout his career.

'The association has given me so much over the years – access to a network, development training schemes and support when I was struggling to pass my exams. Giving back through the HFMA is about helping people get some of the experience and support I have received through my career,' he says.

'I can't wait to get back to when we can associate as a branch, go together to our national conference and keep our networks strong.'

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