# healthcare finance

**December 2021** | Healthcare Financial Management Association

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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**
Seacourt

**HFMA**
HFMA House
4 Broad Plain
Bristol
BS2 0JP

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

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

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




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# RESTORATION AND RECOVERY:

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Baxter Healthcare Ltd.
Wallingford Road, Compton, Newbury, Berks RG20 7QW
Tel: 0800 0289 881

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# News

## HFMA survey: hybrid working is here to stay

By Seamus Ward

Covid may have shifted finance staff working patterns permanently to a hybrid model of working both from home and the office, according to a *Healthcare Finance* survey.

The survey, which attracted responses from 50 finance directors in November, sought to understand how the pandemic had affected office working. Unsurprisingly, pre-pandemic, finance staff spent most of their time working at their employer's office, but for most this fell dramatically as lockdowns and other Covid-safe measures were introduced during 2020.

As the country opened up and restrictions eased, staff have generally returned, but not full time, as finance staff are working from home for at least some of their week.

Finance directors estimated that, on average, their finance teams were broadly spending 90% of their time working in the office pre-Covid. But during 2020 and early 2021, this then dropped to close to 10% as the pandemic hit the country. This has rebounded to some extent, with directors suggesting that about a quarter of their finance team time on average is currently spent in the office.

Some pointed out that the arrangements had been different for distinct parts of the finance team during the pandemic. For example, accounts payable and payroll staff were more likely to be working in the office because of technology constraints.

Despite this partial bounce-back, respondents believed that hybrid working is here to stay. Finance directors estimated that in two years' time there would be a more even split between office and home working, with many suggesting three days at home and two days in the office as a possible model (or vice versa).

Some organisations have created policies setting the preferred split between home and office working. In some cases, there are specific days when all staff are required to come in.

One director of a large trust said the change to hybrid working had been made permanently (staff are required to come into the office at least one day in a two-week period), enabling the need for desk space to be reduced by 40%.

One CCG had refurbished its office to facilitate collaborative working on projects, and training and development, to ensure staff are in the office for a few days a week.

A trust said working patterns were dictated by staff preference, though finance staff were working from home apart from going into the office for a meeting now and again.

Not all workplaces have embedded a new working model, and are still principally working from home.

Responses highlighted the need to recognise that home working was not right for everyone. Some staff did not have the right space or circumstances to work from home.

'If someone would prefer to be in 100%, we will support it,' one trust director said. 'We will look to have everyone coming in roughly 40% of their time at least to keep in touch with the rest of the team.

'As we support clinical services who are running face-to-face services, we also think it is important to be available to clinicians and managers who want to drop in and see members of the team.'

This feeling that it is important for finance staff to spend time in the office, allowing them to meet their customer groups who work on site, was echoed by another acute trust director.

'We need to be alongside them, and we need people to feel part of the team again. Remote working can lead to separation within the team and loss of team identity,' they added.

There were other constraints on home working. One large provider's finance director said technology had prevented some workers, including payroll and accounts payable staff, from working remotely, while others in the finance department, such as management accountants, have been able to work mostly from home.

Overall, they estimated that this meant 50% of finance staff time had been spent in the office in 2020 and early 2021.

Despite the significant move to remote working, the finance directors polled were almost equally split over the impact of home working on productivity – 40% believed it improved productivity, 36% said it reduced it.

However, respondents were positive about the benefits of home working. Most thought it led to a better work-life balance for staff, reduced infection risk, cut the amount of office space needed and reduced the carbon footprint.

Others said that previously the team had worked at multiple sites and online meetings had brought them closer together.

Some respondents said remote working had improved staff retention, and this had been helped by new flexible working arrangements and the trust implicit in those arrangements.

However, others believed the ad hoc conversations in offices that can lead to problem-solving were missed.

The potential lack of separation between home and working life was seen as the biggest drawback of home working – cited by 86% of respondents. And 56% said remote working made it more difficult to performance manage or support staff.

'Finance staff adapted quickly and positively to the pandemic, with many working from home full time,' said HFMA policy and communications director Emma Knowles.

'There are concerns about mental wellbeing and performance management, and for staff who cannot work remotely, either due to personal circumstances or the technology they use.

'However, as restrictions have eased, finance departments are moving to a mix of home and remote working – a change that could stick in the longer term.'

**"Finance teams are moving to a mix of home and remote working – a change that could stick long term"**
**Emma Knowles (pictured)**

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# Julian Kelly: NHS needs to find way to restore output

By Steve Brown

Money will feel tighter in 2022/23 despite significant increases in NHS spending compared with the *NHS long-term plan* settlement, according to NHS England and NHS Improvement chief financial officer Julian Kelly. The NHS will also need to reset the way it works in the new Covid world.

Speaking to *Healthcare Finance* ahead of the HFMA annual conference, Mr Kelly said the spending review settlement had provided the NHS with some £9bn more than was originally anticipated in 2019's long-term plan. 'That's a lot of money and there is genuinely quite a lot of extra capital,' he said. 'But it will feel tight.'

He acknowledged the real pressures facing the service, both in terms of increased emergency demand and a rising backlog of elective activity.

There has been an understandable fall in NHS productivity as social distancing measures and infection control have reduced capacity over the past 18 months. The task now is to find ways to reduce the impact of the constraints the service has been operating under.

'I think the biggest challenge for us operationally and financially is to work out how we can reset and reorganise our services to better live with Covid,' Mr Kelly said. 'Covid remains a highly infectious disease and we need rigorous infection control regimes. But how do we organise ourselves so that it is not a permanent 10% hit to our output?'

As an example, this may mean finding ways to reclaim theatres that have been repurposed as emergency department assessment units. And the service is likely to need a more localised approach to making risk-based decisions. Alongside this, the transformation of pathways to 'left shift' services from acute into community settings will be more important than ever.

One reason allocations may seem tighter in 2022/23 is because NHS England and NHS Improvement will continue to reduce specific Covid-19 allocations – a process already started in the second half of 2021/22.

However, Mr Kelly says this should still cover any additional costs related to Covid. 'What people are telling us they are spending as additional costs of Covid are materially lower than in 2020/21,' he said.

**"How do we organise ourselves so that Covid is not a permanent 10% hit to our output?"**
**Julian Kelly (pictured)**

Trusts will continue to receive funding to cover their actual additional costs and any reduction will be counterbalanced by an increase in the funding available for elective recovery.

Another noticeable difference will be the lack of specific hospital discharge funding – with the government having indicated this scheme will stop at the end of March.

System allocations will be published before the end of December. The plan is to publish one-year revenue allocations and as much capital as possible across three years.

The one-year revenue allocation is to enable NHS England and NHS Improvement to sense-check that the 'baseline funding flows are in the right place' before committing to a longer-term settlement.

There are a number of uncertainties around system funding. Providers have been funded to break even during Covid and there has been a reduced efficiency requirement. Some providers, for example, were running deficits as they entered the pandemic and had their income guaranteed and then topped up.

In fact, Mr Kelly said that 'almost every system is spending materially more' than its baseline allocation, as indicated by the needs-based formula. Integrated care board allocations will also be converged over time with their fair share allocation, and those furthest above target will face smaller growth in future years than those under target or closer to target funding.

'Before I finalise the last two years [of the settlement], we need to do some work to make sure the baseline funding is in the right place,' he said.

Three-year capital allocations should provide the service with greater opportunity to plan infrastructure spending. While Mr Kelly is clear that the NHS has had a good capital settlement, the demands on the funds are also high, with a major hospital rebuilding plan under way.

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## Costing, payment systems and One NHS Finance

Mr Kelly remains committed to exploring how **costing** data could be collected more frequently and fed back to the service more quickly.

'The kind of data that we collect is extraordinary,' he said. 'I personally think it needs to be more timely. The fact that we are publishing it with a 12- or 18-month lag means it is not as useful as it could be.'

However, moving to more regular collection could mean focusing on data that is 'good enough' and ensuring it is standardised so that collection can be more automated. 'We've not solved that yet, but it is still my ambition,' he said.

On **payment systems**, Mr Kelly rejected suggestions that the service should continue to use block contracts as it moves forwards into system working.

'You need to have something that is clear about economy and efficiency and where you know what the cost of the service is,' he said. And incentives will still be important under the new aligned payment and incentive approach, with a 'strong volumetric element' for next year to encourage elective recovery.

He said that 2019/20 would continue to provide the benchmark for activity levels as the last year before the Covid pandemic.

Mr Kelly is fully committed to the **One NHS Finance** initiative, which recently published its five-year development strategy.

There are separate workstreams to develop finance practitioners, the finance community as a whole and the systems and processes that they use.

Mr Kelly says he is determined the function will be more representative and diverse – particularly at the more senior levels – and says the focus has to be on shared learning and spreading good practice.

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**Phil Garland**
Commercial Director UK
Phil.Garland@logex.com
+44 (0) 7985 135895

**James Wilson**
Commercial Director UK
James.Wilson@logex.com
+44 (0) 7931 773418

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The funding may not allow the service to make major inroads into its backlog maintenance – now £9.2bn – but Mr Kelly said he hoped the service could 'stabilise' this figure. And he suggested that specific capital funding for acute capacity and to increase digital maturity across the NHS could free up some headroom within system allocations.

'We have been given quite a lot more capital,' he said. 'It will not solve all our problems, but it should mean we can go significantly further than we otherwise would have.'

Mr Kelly also recognised that, while the service has a huge task in terms of recovery and broader transformation, it is also overseeing a major restructuring exercise with the move to systems from next April.

The creation of 42 integrated care boards, integrated care partnerships and provider collaboratives is a major undertaking, and finance professionals are at the centre of setting up new governance arrangements and closing down old bodies.

He accepted the pressure on staff, and the ongoing demands of the pandemic, but said the benefits of greater integration would help the NHS meet its significant challenges.

'I'm not sure we are going to get a better moment,' he said. 'And we still believe this is absolutely the right thing to do for the long-term strategy for the NHS.'

# Department sets out winter plans

The Department of Health and Social Care has unveiled how it plans to use additional funding to support the NHS through the winter.

Additional NHS funding in the second half of 2021/22 was set at £5.4bn, and the plan – *The health and social care approach to winter* – which was published at the beginning of December, allocated £700m of this funding as capital, digital and revenue funds.

It aims to help reduce waiting lists by expanding wards, opening new day surgery units, installing permanent and modular operating theatres, and upgrading outpatient spaces and MRI and screening technology.

Health and social care secretary Sajid Javid (pictured) said: 'Ahead of what is going to be a difficult winter, we're putting everything behind our health and care services, so that everyone can access the services they need, when they need them.'

# Government's care plan prompts mixed response

**By Seamus Ward**

The government's adult social care white paper has received a mixed response. Although elements were broadly welcomed, there was disappointment in the levels of funding allocated and the vision for workforce.


In September, prime minister Boris Johnson allocated £5.4bn over three years to pay for social care reforms, funded by a new health and social care levy. In the spending review, it was confirmed that £1.7bn of this would be used to pay for major improvements in the adult social care sector.

The government said the white paper, *People at the heart of care*, offered a 10-year vision to improve adult social care, including greater choice, certainty over costs, and opportunities for care providers. It set out how around £1bn of the £1.7bn will be spent to reform the system over the next three years, with further allocations to be made as the social care reform programme progresses.

The funding includes £500m for staff training and development, and £300m for investment in housing to help local authorities offer greater choice, care and support. For example, a new service will repair or alter homes to help service users remain safe, stay with their family or live independently if they wish.

At least £150m will fund the adoption of technologies and digitisation, including digital social care records. The white paper commits to 80% of social care providers having a digital care record that can connect to a shared care record by March 2024. Implementation support for proven technologies will be funded in each integrated care system.

More than £70m has been set aside to improve delivery of care and support services, helping councils to better plan and develop the options available. Smaller amounts have been allocated to other programmes, such as supporting carers (£25m) and innovation (£30m).

Integrated care partnerships (ICPs) will have a key role in the 'necessary integration of housing within health and care', and further details of how ICPs and integrated care boards will support the delivery of joined-up care will be set out in the upcoming integration white paper.

Commons Health and Care Committee chair Jeremy Hunt (pictured) said that the government deserved credit for 'grasping the nettle' of

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social care reform, but it had failed to recognise the scale of additional resources needed.

He said: 'Failures in social care will continue to put pressure on our overstretched hospitals with patients who cannot be safely discharged, exacerbating the winter crisis, and thousands of people will not get the care they need because the carers do not exist.'

Nuffield Trust deputy policy director Natasha Curry asked if funding would be overstretched. 'The money allocated must fund the cap on costs and higher means-testing, as well as make care fees fairer and support care providers at risk of collapse. Beyond the initial three years of the levy, it also heavily banks on the actions of future governments and assumptions that funding can be diverted from the NHS to social care.'

The white paper said the £500m training and qualifications fund would give staff opportunities to progress their careers, while some of the funding would go towards supporting the mental health of the adult social care workforce.

Mr Hunt said although the paper had taken into account the need to recruit and retain staff, it had not gone far enough. 'Social care needs its own people plan, and a detailed 10-year strategy setting how these ambitions will be achieved.'

Despite the workforce difficulties faced by the social care sector, Ms Curry said there were no proposals on addressing low pay. 'The white paper cannot be another missed opportunity to address social care properly and provide real improvements for staff, carers and people who need support now and in the future,' she said.

However, Oonagh Smyth, chief executive of workforce development charity Skills for Care, said: 'Much of the workforce elements in the white paper are measures we and others have been asking for. The commitment to invest in professional development, and in our key leaders like registered managers, is something we have been talking about for some time.'

# News review

## Seamus Ward looks at recent developments in healthcare finance

**The past few months have been dominated by decisions on NHS spending in England – both for the second half of the 2021/22 financial year, and for the next three years – as the government delivered its spending review in October. Most of the health spending news was released in September, with the government allocating an additional £5.4bn in England for the final six months of the current financial year. This includes £2.8bn to cover Covid costs, while £1bn has been set aside to continue elective recovery. There was also £478m for the discharge to assess programme, and £500m in capital funding for additional theatre capacity and technology that will increase productivity. A further £600m was allocated for 'day-to-day' costs.**

Looking further ahead, the government said NHS England would benefit from extra funding of almost £16bn over the three years to 2024/25, with social care receiving an extra £5.4bn. The NHS will receive £9bn over three years to tackle elective recovery, with the target of increasing activity to 30% above pre-pandemic levels. There will also be funding for technology that will aid elective recovery and hospital and theatre productivity (both £250m). The spending will be paid for with a 1.25 percentage point increase in National Insurance from April 2022 – which will subsequently become a health and care levy on earnings from 2023. There will also be a 1.25 percentage point rise in dividend tax rates. Overall, health spending will grow by £36bn over the three years, including Barnett consequentials for the devolved administrations (£5.7bn).

November's Budget and spending review confirmed these rises, setting overall capital spending at £10.6bn, £10.4bn and £11.2bn respectively for the coming three years, compared with £9.4bn in the current year. There was no detail on specific Health Education England (HEE) budgets, but the government committed to 'building a bigger, better trained NHS workforce' and providing 'hundreds of millions of pounds in additional funding' to underpin this.

Subsequently, the government announced that HEE would merge with NHS England and NHS Improvement, insisting that the merger would put long-term planning for healthcare recruitment and retention at the forefront of the national agenda. HEE said the merger would bring finance and service planning together with workforce planning and development. NHS Digital and NHSX will also merge with NHS England and NHS Improvement.

Additional funding was announced in Scotland and Northern Ireland. The Scottish government allocated a further £482m to NHS boards and integration authorities to meet the costs of the pandemic and remobilising health services. The sum includes £121m for Test and Protect and £136m for the vaccination programme. The rest of the funding will cover additional staffing to support hospital scale-up, equipment, maintenance and IT.

Health and personal social services in Northern Ireland were allocated a further £200m this year. Finance minister Conor Murphy said that the administration's share of Barnett consequentials from the NHS spending rise in England for the rest of 2021/22 had not been confirmed. However, he had made the allocation to ensure local health and social services receive the funding as soon as possible. Mr Murphy said £80m will be spent addressing Covid-19 hospital service pressures; there will be an extra £70m to cover the 3% pay award; £30m to address elective care pressures; £15m for health and social care trusts; and £5m for the Mental Health Support Fund.

## The news in quotes

'Health staff have worked tirelessly throughout the pandemic, caring for patients in the most challenging of circumstances – £70m will be used to fund the health staff pay awards requested by the Department for Health.'

**Northern Ireland finance minister Conor Murphy sets aside funding for staff pay rises**

'We expect 41% of UK consultants to retire over the next decade. The opportunity to take a long-term approach to prepare for these challenges ahead has been missed.'

**Royal College of Physicians president Andrew Goddard laments MPs' rejection of proposed changes to the Health and Care Bill**

**'This report highlights action that is being taken but rightly reminds us that far more urgency and impact is needed in every part of the NHS.'**

**The NHS must act now to tackle discrimination, says NHS Employers chief executive Danny Mortimer**

**'This funding will go straight to the frontline to provide more patients with the treatments they need but aren't getting quickly enough. We will continue to make sure our NHS has what it needs to bust the Covid backlogs and help the health service build back better from the worst pandemic in a century.'**

**Boris Johnson pledges financial support for the NHS**


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**Rishi Sunak delivered the Budget and spending review, confirming an increased settlement for NHS England**

While attention has been drawn to the Covid pandemic and the government's spending plans, some NHS staff have been unsettled over their pay awards for 2021/22. The Royal College of Nursing has held indicative ballots on industrial action in England, Scotland and Wales. In Scotland, nine in 10 RCN members backed industrial action short of a strike, while 60% supported strike action. They had rejected the 4% offer in May. The union said it would use the result to consider its next steps.

In England, 89% were willing to take action short of a strike, while 54% would withdraw their labour. The strength of feeling was similar in Wales, with 91% voting for industrial action but not a strike, and 56% backing a strike. The union will now consider its next steps. In October, 90% of Unite union members in England rejected the 3% award in a consultative ballot, with 84% willing to take industrial action. However, the turnout was not enough to meet the threshold for industrial action. The British Medical Association said junior doctors will intensify their pay campaign after they were not included in the 3% increase – juniors are part of a multi-year pay agreement and have received a 2% pay rise.

Workforce – both shortages and the need to plan for the future – was a theme that has run through the past three months. An amendment to the *Health and Care Bill,* backed by more than 60 health and care organisations, which would have required government to publish independent annual assessments of current and future workforce needs, was rejected by MPs. In a joint survey, the Royal College of Physicians, the Royal College of Physicians of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow found the proportion of vacant medical consultant posts across the UK is at the highest level in almost a decade. The survey showed nearly half (48%) of advertised posts were unfilled last year, an increase of 12 percentage points since 2013. Lack of applicants was the main reason the posts were vacant (49%), while 34% were not filled due to a lack of suitable candidates.

A Nuffield Trust analysis showed the number of full-time equivalent nurses rose by 14,158 in the last two years. It said that 'on the face of it, this appears to be the right level of growth' to achieve the government's manifesto commitment of a 50,000 increase by 2025. However, it warned against complacency, and said there was no precedent for such a sustained increase. An annual increase of 10,000 more nurses has only been achieved four times in 62 years.


The NHS does not have the tools to address inequality between NHS staff groups, according to a Nuffield Trust report. It said that despite considerable effort, inequality may even have got worse. *Attracting, supporting and retaining a diverse workforce*, commissioned by NHS Employers, said there was a lack of data, less-high-profile groups are being overlooked, and there is poor understanding of what works to improve diversity. Lack of inclusion meant worse patient care and hindered the NHS ability to recruit and retain staff, it added.

## from the hfma

In a recent blog for the HFMA website, outgoing president Caroline Clarke reflects on her two years in office, covering what has been a challenging time for both the NHS and the association. She talks about her joy of recently being able to attend branch conferences in person rather than virtually, and the ups and downs as she remained president for a second year to help see the association through the pandemic.


**With the UN's COP26 climate conference taking place in Glasgow, the HFMA provided a wide range of briefings, webinars, and blogs supporting members to play a role in making the NHS environmentally sustainable. In a blog, association chief executive Mark Knight outlined the HFMA's own actions, including switching the magazine's packaging from plastic to recyclable paper and an environmentally friendly printing process. The HFMA published its green pledges, and is taking the opportunity to embed sustainability in its new Bristol headquarters.**

HFMA policy and communications director Emma Knowles blogged about the autumn Budget and spending review, while Health Foundation research director Anita Charlesworth (pictured) urged the health service to make more payment reforms beyond the implementation of the aligned payment and incentive system to be introduced in 2022.

**See www.hfma.org.uk/news/blogs and www.hfma.org.uk/publications**

# Comment

**December 2021**

## Coming together

### New HFMA president Owen Harkin says the UK nations have much to learn from each other

**I am immensely proud** to become only the second person from Northern Ireland to be HFMA national president. Though I know the Northern Irish system best, I am keen to be the leader of finance colleagues from across the UK.

We are all in different positions. While England is preparing to embark on closer integration in April, in Northern Ireland we are nearly 50 years down the road of bringing health and social care together, with integrated services, integrated organisations and health and social care trusts. Though we have years of integration under our belts here in Northern Ireland, no-one would claim it is perfect.

HFMA president Owen Harkin

However, like England, we are embarking on a period of reform, led by our Department of Health. Our commissioner, the Health and Social Care Board, is due to close on 31 March 2022 and its staff will move to the Department of Health to create a Regional Group, which will provide oversight, co-ordination and accountability functions.

This will be underpinned by the creation of area integrated partnership boards (AIPBs), including membership from the local trust, primary care, local government, and the community and voluntary sector, These five AIPBs will be accountable to the Regional Group.

Trusts will still exist under this new integrated care model, but questions remain over how wide the powers of the AIPBs will be, and whether the new system will be underpinned by the same performance management mechanism.

There is also recognition of the cultural change required across the full

## Finding the right balance

### Finance teams must maximise the value of hybrid working

**The pandemic has left a permanent** mark on the country, changing how people live their lives and interact socially. For many, it has also changed their working lives.

In September, a BBC poll found that four out of five business leaders thought it was likely that people will never return to offices in the same numbers as before. This also appears to be the case within NHS finance departments, according to a new HFMA survey of finance directors (*see page 3*).

Last year, finance teams switched to home working almost overnight. IT and connectivity problems were rapidly sorted, enabling finance teams to keep to their duties, including preparing annual reports and accounts. It was a lesson in what can be achieved when the pressure is on.

The survey underlines this overnight change. Finance directors say their teams went from being broadly in the office for 90% of the time to only averaging around 10% of their time in the office – although the picture varies from organisation to organisation.

But there is a clear feeling that the eventual steady state will be a hybrid model, with staff splitting their time between office and home. People cited different possible models – three days in and two days at home, or vice versa, for example.

Healthcare Finance editor Steve Brown

**"The whole of health and social services in Northern Ireland is equivalent to one large ICS in England but we face common issues"**

range of constituent partners to ensure the success of the model, with the expectation that a better understanding of the roles and responsibilities of each partner will be vital in constructive collaborative working. I hope we can all build on the co-operation we saw during the pandemic.

I am aware that the whole of health and social services in Northern Ireland is equivalent in size to one large integrated care system in England. But we still face common issues, including the immediate challenges of winter. This is shaping up to be the most challenging ever faced by the NHS, placing enormous strain on our hospital and critical care capacity, and the need to maintain flow through our emergency departments and into social care settings.

But there are many other common questions. How can we make our services more sustainable, embrace the digital agenda, address workforce shortfalls and, broadly speaking, make the most of our cumulative resources to ensure we provide the best outcomes for the populations we serve? All this while addressing the major health inequalities so visibly exacerbated by the pandemic.

I think there is much we can do by bringing the nations together to share ideas and experiences.

In November, we had the first meeting of our new HFMA Devolved Nations Group, which included branch chairs and senior finance leaders from each nation. We talked about what we can do in terms of collaborative research, and joint publications, webinars or podcasts over the next 12 months. We could all contribute to these, and include input from the NHS in England as well.

My theme for my year as president is *Reimagining the future*, and it will have three parts – the short-term recovery of the NHS from the Covid pandemic; longer-term changes to the NHS; and the future of the HFMA.

I am looking forward to discussing and developing the theme with HFMA members over the coming months. I've always said the members are the most important element of the association, and I want to meet and talk with as many members as I can.

I can't wait to get out there.

• *See profile, page 30*

*Contact the president on president@hfma.org.uk*

There are clearly pros and cons. There were differing views on whether productivity was better or worse when working at home. But there was a consensus on the benefits of reducing commuting time and improving work-life balance, albeit recognising that working from home can make it difficult to separate work and home life. And some people simply do not have a suitable 'home office' environment to work from.

One of the clear challenges of working from home is the reduced opportunity to interact with colleagues and clinical teams – the loss of 'corridor conversations' or being on hand to support clinical teams.

There have been calls for finance staff to improve their knowledge of the 'business' of healthcare. How can they do that if they are one step further removed from the frontline?

Clinical-financial engagement is already vital – from budgetary control, to the delivery of efficiencies, the development of business cases and establishing robust patient-level costs. This will become even more important as a greater level of financial control is exerted while the service looks to meet high levels of emergency demand and address an intimidating elective backlog.

So the new hybrid model of working will have to find ways to retain this engagement. In fact, engagement will need to increase.

The move to population health

**"There have been calls for finance staff to improve their knowledge of the 'business' of healthcare – how can they if they are a step removed from the frontline?"**

management and the need to address health inequalities (*see Levelling up, page 13*) will also put a focus on data. Finance practitioners will be relied on to help clinicians understand where the opportunities for improvement lie, and the costs and value associated with different plans of action.

Online meetings have been a revelation, helping to keep teams together and, according to some reports, enhancing team spirit. But they do not work in all circumstances.

The One NHS Finance team, through the Future-Focused Finance programme, is leading work around hybrid working models. This is important – sharing experience and good practice will be vital as NHS finance teams look to find the right balance.

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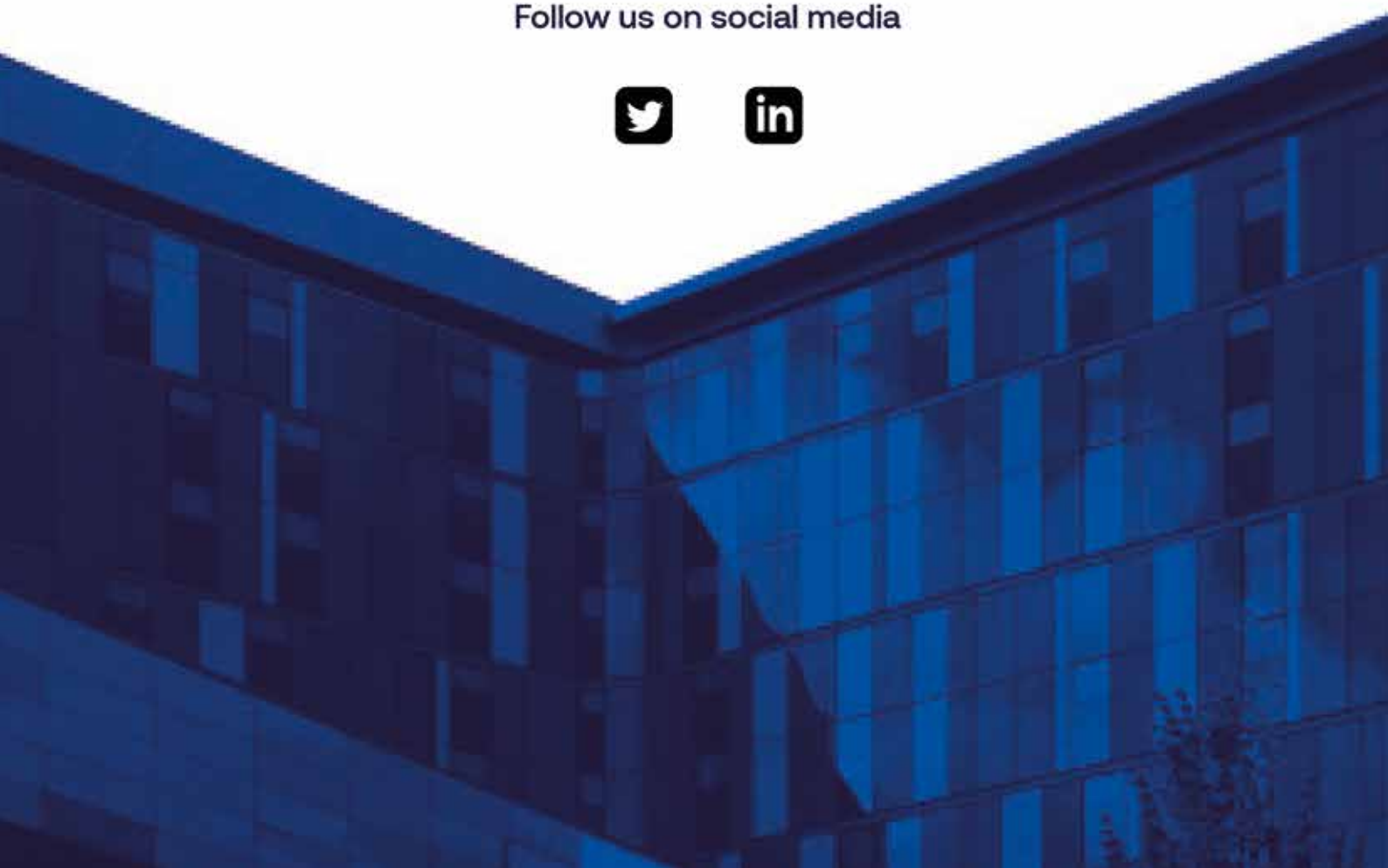

# Levelling up

**Addressing health inequalities is a priority for health systems. Steve Brown reports on how parts of the service are gearing up for the work and how finance practitioners are getting involved**

Health inequalities are nothing new. The most recent figures from the Office for National Statistics showed a 9.4-year gap in life expectancy for men between the least and most deprived areas in England (7.6 years for women). And the gap in healthy life expectancy is closer to 20 years.

Covid-19 has pushed health inequalities even further into the spotlight. There has never been such a focus on addressing these issues as there is now.

The pandemic's unequal impact on the population is well documented. Although old age has been the biggest risk factor, the virus has hit deprived areas and some ethnic groupings harder.

A Public Health England report in 2020 said that among confirmed Covid cases, people of Bangladeshi ethnicity had around twice the risk of death compared with white British people. And those with Chinese, Indian, Pakistani, other Asian, black Caribbean and other black ethnicity had between a 10% and 50% higher risk of death than people who define themselves as white British.

There were also more hospitalisations and higher death rates in the most deprived areas. Waiting lists have grown more rapidly in these places – and they could also have larger numbers of the millions of 'missing' patients who didn't come forward for treatment during the past 18 months.

All of this has helped to put addressing health inequalities at the top of the agenda.

The planning guidance for the second half of the current year in England made this absolutely clear, restating the five priority areas for tackling health inequalities:

- Restore services inclusively
- Mitigate against digital exclusion
- Ensure datasets are complete and timely
- Accelerate preventative programmes for those at greatest risk of poor health outcomes
- Strengthen leadership and accountability.

**The virus has hit some ethnic groupings harder. There were also more hospitalisations and higher death rates in the most deprived areas**

## NHS contribution

While many factors driving health inequalities are outside the direct responsibility of the healthcare sector, a paper to an NHS England and NHS Improvement board meeting this year said the NHS could contribute in three ways. First, it could influence multi-agency actions to address social determinants. Second, as a 'significant economic actor in its own right', its actions as an employer, purchaser and local anchor institution can help to moderate inequalities. Third, it can tackle inequalities in healthcare provision – disparities in access to services, patient experience and outcomes.

As director of the health inequalities improvement team at NHS England and NHS Improvement, Bola Owolabi has been central to this increased focus on health inequalities.

She believes data holds the key to addressing inequalities – you need to see the problem before you can address it. But this means looking at data broken down to the right level.

'It is now hardwired into the operational planning guidance that boards will disaggregate data by deprivation and ethnicity going forward, so we can actually see what lies under the bonnet,' she told a recent HFMA conference.

She believes the Covid vaccine campaign stresses the importance of getting beneath the headline data. According to uptake data in January 2021, 82% of the over-80s had had their first jab. But within that, uptake among black Africans was just 38%, for Pakistanis 44%


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and for those living in the 20% most deprived communities 45%. It was being able to view the data in this way that enabled problems to be spotted and improvements made to target specific populations for improved uptake.

Addressing health inequalities could require prioritisation of specific groups within existing budgets or it could lead to increased costs as the service responds to previously unmet demand. That appears challenging given tight finances and a daunting backlog of activity.

Dr Owolabi wants the service to focus on the costs of doing nothing. The original Marmot review estimated that direct treatment costs in England associated with inequality amounted to £5.5bn a year. Productivity losses were put at £31bn-£33bn, with lost taxes and higher welfare payments costing between £20bn and £32bn a year.

'People from the most deprived areas have lower life expectancy and yet the per capita cost of healthcare in these areas due to emergency admissions, long-term conditions and prolonged length of stay in hospital means a higher healthcare cost in their fewer years of life compared with affluent areas,' she says.

The human cost also makes for difficult reading. '27.2% of mortality from cardiovascular disease under the age of 75 is among people in the 20% most deprived communities,' Dr Owolabi adds.

'And 41.5% of avoidable mortality from chronic respiratory disease is again represented in that 20% most deprived.

'If you look at maternity,' she continues, '[the Mbrrace-UK report shows that] black women are four times more likely to die in childbirth or in the year following birth and Asian women are two times more likely. That is the cost of doing nothing.'

The challenge for many health systems will be knowing where to start. The response from NHS England and NHS Improvement is a new programme called Core20plus5.

This calls for systems to focus efforts and energy differentially on those 20% most deprived communities, plus other population groups experiencing poorer than average healthcare access, experience or outcomes, such as ethnic minority communities, as identified by local population health data.

There is also an emphasis on five key clinical areas of health inequalities:

- Early cancer diagnosis
- Hypertension case finding
- Chronic respiratory disease
- Annual health checks for people with serious mental illness
- Continuity of maternity carer plans.

This will be supported by a health inequalities improvement dashboard, which will enable systems to measure, monitor and gain insight to make improvements to narrow health inequalities.

It covers the five priority areas in the 2021/22 planning guidance, as well as the five clinical areas in the Core20plus5 approach. By providing data by ethnicity and deprivation, the dashboard will enable the NHS to take concerted action to improve health inequalities.

## LLR initiative

One system putting its money where its mouth is on addressing health inequalities is Leicester, Leicestershire and Rutland (LLR). The three constituent clinical commissioning groups have introduced a general practice funding formula that better reflects health inequalities across the system.

'I'm sure that if you look at every system strategy, it would talk about a left shift,' says the CCGs' chief finance officer, Nicci Briggs. 'Yet when you look at everyone's finances, you continue to see massive growth in secondary care and lower growth in community and primary care.'

She says the new local approach addresses concerns with the national Carr-Hill practice funding formula, which has been used relatively unchanged since 2004.

'The two largest elements in the Carr-Hill formula are age and gender, so you get more funding if your population is older. But the areas with the most deprivation have a lower life expectancy,' Ms Briggs says. 'That is just a fact.'

In response, the CCGs have adopted the Johns Hopkins Adjusted Clinical Group (ACG) system. This population health analytics tool enables systems to develop an in-depth understanding of population characteristics.

It has already been successfully used in Sweden to support a more equitable reimbursement system for primary care.

The LLR system has used this greater understanding to develop its own capitation formula, with weightings for a wider range of issues that reflect population needs.

For example, it takes account of communication issues. If a practice serves a larger community of people for whom English is not their first language, consultations may take longer.

This might mean fewer people are seen overall or that more practitioners are needed to deliver the same level of service. And that should be reflected in practice funding.

The Carr-Hill formula does adjust for factors outside of age and gender – for example, morbidity and mortality, number of care home residents and list turnover.

However, Ms Briggs says the difference is that the LLR approach takes its data from the system's own patients, while the existing national formula simply applies national percentages. 'And when [the national approach] is divided up at practice level, it doesn't necessarily result in more payments to those practices that have high- and multi-morbidity,' she adds.

The new formula is potentially redistributive – 29 practices were shown to be 10% away from target funding when comparing the new model with existing funding. And eight were more than 15% away from target.

Following wide-ranging consultation, the LLR system implemented its new approach in July on a 'no losers' basis.

Protecting practice income in this way encouraged support for the change among the GP community but did require extra investment. However, this only amounted to £3m.

'Leicestershire is a £1.7bn health economy,' says Ms Briggs. 'This isn't huge in overall terms, but it has led to some practices receiving a 20% increase – showing just how underfunded they were.'

The local funding model does not cover all practice income – quality and outcomes framework payments, premises costs and dispensing monies are all excluded.

However, it does dictate the distribution of more than two-thirds of the system's £180m primary care budget across 133 practices.

At the same time, the new approach has

**"It's now hardwired … that boards will disaggregate data by deprivation and ethnicity, so we can actually see what lies under the bonnet"**

**Bola Owolabi, NHS England and NHS Improvement**

## Financial contribution

Finance teams have a major part to play in moves to reduce health inequalities. While there is a big push for systems to ensure datasets are complete, finance professionals' jobs will be putting these wide-ranging datasets alongside patient-level cost data – and in future, whole pathway patient-level costs (Plics). They will need to help signpost the inequalities to be addressed, highlight the short- and long-term costs of these inequalities, and understand the costs of reducing them.

It is a huge task, but one that many finance teams are already grappling with. Leeds Teaching Hospitals NHS Trust is one of the more advanced, having developed a Plics population health management analyser to support its population health management approach to improving outcomes (*see Healthcare Finance March 2021, page 30*).

The system enables activity and costs to be analysed by geographical location and levels of deprivation or ethnicity. It also pulls in data about lifestyles – alcohol consumption, smoking, body mass index, diabetes status – although this is based on the trust's own internal data collection and so is not a complete dataset.

Vinod Bassi (pictured), the trust's assistant director of finance, says that initial work turned into a dashboard that supported a Shape up for Surgery initiative. This aims to support improved outcomes by getting patients to adopt different lifestyle choices ahead of surgery.

But word got out about what the finance team could do, and with health inequalities a major priority for the trust, it has been inundated with requests to develop different dashboards.

'We've done an outpatients did-not-attend dashboard to see if there are demographic factors that impact on attendance at clinics,' Mr Bassi says.

'We've also looked at cancer pathway and critical care and we've produced a dashboard for accident and emergency, which, for example, looks at whether people arriving at A&E via different routes – ambulance or walk-in, say – are receiving different responses. And it has helped us to explore the amount of time spent in A&E based on age and ethnicity.'

Mr Bassi says there is massive interest in the trust around population health management and health inequalities. 'There is so much data that you can't fit it all into a one-size-fits-all tool or dashboard, which is why we have so many distinct ones on the go and working with lots of different people at the same time,' he says.

There is a concern that a lot of the work around using data is being taken forward in the provider sector, where arguably there is, in general, better quality activity and cost data.

Some finance managers argue that this initiative should be driven by systems, looking across acute, community and mental health services, as well as primary care and local authorities.

Peter Fry, head of costing and service line reporting at Somerset NHS Foundation Trust – a fully integrated trust delivering acute, community and mental health services – says trusts are having to go 'from zero to 60' on health inequalities.

Building on ideas that other people have implemented – and understanding the mechanics – would help people to get started. So he would also like to see a more structured approach to sharing through case studies and best practice examples.

The Somerset trust has been co-ordinating regular workshops with other provider costing teams to demonstrate that it has mapped deprivation to Plics data. It is also an opportunity to share ideas across teams and get into the detail of data matching and dashboard building. He is keen to expand the group if organisations are interested.

Information governance is an issue that NHS bodies need specific help with. Mr Bassi says there is powerful information in its A&E analyser that ambulance services would be interested in – for patients transported to hospital but released without treatment, would a referral to a different service have been a better solution?

'Our ambulance service is really keen to make use of this, but there are a lot of information governance hurdles that we have to overcome,' he says.

He is not alone. Another finance manager in a recent HFMA discussion about the finance role in health inequalities said his trust could not get direct access to diabetes HBA1C test results it had undertaken for GPs. Instead, it had to access the anonymised data via a university-run database.

Mr Bassi agrees that the Leeds data would be enhanced if it covered the whole patient pathway, including primary care – potentially enabling clinicians to see the patients they aren't reaching, as well as those they are.

Jason Dean, service improvement and costing accountant at Alder Hey Children's NHS Foundation Trust, believes all systems could do with support on this issue.

He says: 'It feels like something that NHS England and NHS Improvement could drive and facilitate the sharing of data between organisations.'

still seen a major simplification in payments – reducing an estimated 80 different payment lines down to around 30, according to Ms Briggs. That brings time savings both at the centre and within practices. In parallel, the system is looking to harmonise primary care services across its health economy, which could require further investment of up to £1.8m.

LLR is also keen to align what it measures with this new funding approach, moving much more towards collecting outcomes rather than inputs and outputs. All practices will be focusing on addressing their own health inequalities. But Ms Briggs says the system will be able to see the correlation between funding and the rate of improvement from the newly established baseline.

Although it may take time for some improvements to show up, the system anticipates several benefits will be realised much more quickly.

'We recognise that a lot of practices with high morbidity and deprivation struggle on lots of the screening programmes,' she says.

More funding for diabetes, smoking cessation and heart health clinics could deliver fast results. Funding could be used to boost communications in key areas or to target services at parts of the community with known health inequalities – a Bangladeshi nurse to run outreach clinics, for example.

In other areas, with high and long-standing vacancies, the increased funding may enable higher wages to be paid to attract practitioners into the city.

There is a long way to go with addressing health inequalities, but LLR is convinced its person-centred approach is a practical step in the right direction.

And the GP practice – which is how most people enter the health system – is the right place to start.

# How healthcare partnerships supported Trusts and patients in the pandemic

**Kieran Doona**, Head of Healthcare and NHS Pharmacy Services at LloydsPharmacy shares his thoughts on how NHS Trusts can leverage partnerships to drive much-needed efficiencies and improve patient outcomes.

The world of healthcare is changing rapidly. The familiar challenges of capacity, cost and quality still exist, but are now compounded by the effects of an increasingly ageing population as well as a rise in people living with long-term conditions.

The pandemic has brought all this into even sharper focus, and in many ways, accelerated the need to provide patients with the option to access treatment and medicines outside the traditional hospital setting.

The NHS is one of the country's most prized assets and is the envy of the rest of the world. In order to ensure it continues to provide quality care for millions of people, it too needs to look at ways to become more efficient.

I'm delighted to be attending this year's HFMA conference and getting to spend some time with like-minded professionals from the world of healthcare. It's also a great opportunity for us to talk about what we're doing at LloydsPharmacy to support NHS Trusts to meet their objectives.

Our proposition is all about delivering expert, patient-centric services that are financially viable and sustainable long-term.

We already work with a number of NHS Trusts across the country to help them drive efficiencies and free up capacity within their hospitals. Our approach involves spending time understanding what the challenges are for each Trust and how we can help. We then work together to develop and deliver effective treatment pathways that take people out of the typical hospital environment and into a more convenient setting – crucially without compromising quality or patient outcomes.

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These include allowing patients to collect medicines from their local LloydsPharmacy branch instead of from the hospital. And providing a home delivery service, where we dispense and then deliver direct to patients homes. These innovative new approaches have reduced footfall in hospitals, increased capacity as well as supported patient safety.

Another example of how we're partnering with Trusts is through our LloydsPharmacy Healthcare Centres initiative. This concept is designed to give patients the option to get their treatment closer to home, either at one of our healthcare centres, their local LloydsPharmacy branch or a mobile unit. This in turn frees up resource for Trusts and releases capacity in hospital-based clinics.

As you can see, we're on a mission to become the UK's number one integrated healthcare partner. We want to hear from Trusts that understand the need to become more efficient but are committed to delivering great outcomes for their patients.

Find out how we can help you, go to **lloydspharmacyhs.com** to view Trust and patient case studies. Alternatively contact me directly on **07787 558171** or email **kieran.doona@lloydspharmacy.co.uk** to find out more about our pharmacy services.

*Based on average spend of £8m on outpatient medicines, and analysis of current LloydsPharmacy contracts. This is not indicative or guaranteed. ^This is the average for all patient prescriptions.

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## Royal Free approach

While tackling health inequalities has often been regarded as a commissioner or even local authority role, providers also have a big part to play and it will certainly be a big issue for systems.

The Royal Free London NHS Foundation Trust was one of the first trusts to have a public health team in place. Its population health committee publishes an annual report. The 2021 report, *Translating population health: reducing inequalities with every contact,* sets out the trust's aim to embed a 'systematic approach to identify and reduce health inequalities' across the trust. The report highlights a significant gap in life expectancy across the trust's roughly one million population, with a two-year gap even at the borough level.

> **"We have a shared vision – my clinical, procurement, finance and planning colleagues are speaking great public health language"**
>
> **Judith Stanton, Royal Free**

Looking across North Central London as a whole, there is an 11.6-year gap for men (12.3 for women) between the most and least deprived wards. The main causes of the gap are circulatory disease, cancer and respiratory disease.

And again, with differences across the boroughs, on average people are spending their last 15 to 20 years in poor health.

The trust serves a very diverse population, with 150 different languages spoken and about 40% of people black, Asian or from a minority ethnic group.

Judith Stanton, the trust's deputy director of public health, says it has done a lot of work exploring the inequalities that exist in gaining access to services – including the time taken to receive a first outpatient appointment, the time to intervention and rates of non-attendance.

The trust is delivering a programme, driven by health inequalities data, to improve equity of access, reduce health inequalities in targeted specialty areas and reduce the rates of non-attendance. It aims to explore some of the health inequalities that underpin waiting times as well as improve recording of ethnicity data.

There are systemic reasons why patients cannot attend, so the programme will look at improving patient administration processes to communicate more effectively with patients and involve them in making services accessible.

There is still a long way to go, but Dr Stanton insists there is a real opportunity to reduce inequalities and embed equity.

'We all have a shared vision of what we want to do,' she says. 'And my clinical, procurement, finance and planning colleagues are speaking great public health language.'

At the moment, the trust is most familiar with its own service users – and can analyse their use of services by age, gender, deprivation score and ethnicity. But it is also part of the North Central London population health management platform, HealtheIntent, which includes an integrated health and care record.

This means it will gain greater whole-system insight about equity of outcomes, access and experience of the local population, including how health inequalities in groups such as those with serious mental illness, learning disability and multiple disadvantage are playing through.

HealtheIntent will also give the trust the insights to develop its role in population health within the integrated health and care system, including prevention and proactive care.

## Fuller picture

Dr Stanton says that, even without this 'full picture', the trust is trying to take a view of its broader population as part of its accelerated recovery programme.

'We are trying to see who we are missing and who we might normally expect to see,' she says. This involves comparing the make-up of the patients being seen with the demographic profile of the communities it serves.

Dr Stanton says the key is to 'build equity in' as the trust looks to address the backlog all trusts face. This includes work on how to take forward the virtual outpatient appointments that rapidly expanded during Covid. It means ensuring patient views are listened to and that the trust doesn't make assumptions about different groups' preferences or abilities.

'If we put in a universal approach, we need to make sure we have considered what the risks might be to inequalities,' she adds.

The trust has done multiple iterations of trust-wide inequality analyses to check that its methodology is robust. It has already identified gaps in average waiting times and length of stay for different groups of patients.

It also aims to improve recording of protected characteristics in order to bolster the validity of future analyses. Initial meetings are taking place with services and key inequality KPIs have been agreed and are about to be embedded in executive and local performance reporting.

'Ultimately we want to put inequality analyses into routine performance reports for each division or directorate,' says Dr Stanton. 'They will own their data and track their performance. They will be able to see their own inequalities, put any required response into action and then monitor the impact.'

Addressing health inequalities will not be achieved overnight. For issues NHS bodies can directly influence, the key will be embedding good practice into everyday processes. That means understanding performance across different groups and ensuring access and provision is matched to their needs.

# NHS finance careers: make your career count

In the first of a series of CIPFA webinars, leading senior finance professional and CIPFA member Bob Alexander talks with recently CIPFA-qualified financial planning analyst for NHS England Tahmid Ahmed about future careers in the NHS, crucial support for leadership – and why it's vital to be open to change

**Being a finance professional in the healthcare sector is a challenging vocation – but also a rewarding and fulfilling one for those considering a career in finance. As demonstrated in particular over the past 18 months in the NHS's response to the COVID pandemic, the qualities demanded of the modern healthcare finance professional include flexibility, agility and responsiveness to fast-changing circumstances – but, crucially, these must also be underpinned by the fundamentals of a solid foundation in robust public financial management. As the only professional accountancy body in the world exclusively dedicated to public finance, CIPFA's portfolio of qualifications are the foundation for a career in public finance.**

In the first of a series of CIPFA webinars, on the subject 'NHS finance careers: make your career count', leading senior public sector finance professional Bob Alexander discusses the challenges, opportunities and rewards of a career based around the NHS with recently CIPFA-qualified NHS England financial planning analyst Tahmid Ahmed.

Bob Alexander (BA): What was it that made you want to join the NHS and the public sector finance family?

Tahmid Ahmed (TA): It started during university when I did a placement at University College London Hospitals – I very much knew early on that I wanted my career to have a greater goal than just making a profit. I wanted to give back to patients and the community, so I decided that I wanted my career to be focused on the public sector. While I was on my placement, I worked with great colleagues who were really focused on delivering the best care that they can to patients, and that really inspired me to move forward with my career within the NHS. After leaving university I was accepted onto the NHS Graduate Management Training Scheme. Over the three-year scheme, I rotated around two main placements as well as across other areas within the organisation. I graduated in September, and although there have been challenges at times, I've thoroughly enjoyed my career so far within the NHS, and my current role as a financial planning analyst at NHS England. I'm looking forward to how my career develops – hopefully it will be as broad and vast as Bob's...

(BA): I didn't have the classic public sector finance professional's career path – I certainly didn't set out with a plan for it to be so varied. I wanted a career in public sector finance but wasn't too specific about where – I just enjoyed the complexity of dealing with the social issues and challenges against the backdrop of often challenging financial circumstances. I first joined the London Borough of Wandsworth as an internal auditor which, it turned out, was a fantastic way of getting around an organisation and understanding how a local authority works. It gave me a good grounding while still learning the technical issues around public sector finance, which was incredibly useful.

(TA): I agree – getting that rounded experience on the grad scheme around many roles in finance really helps. I had the opportunity to work in management accounts, income, patient level costing, and much more. I'd advise anyone not to close yourself off to opportunities that might be great for you, just because you have an idea of what your future might look like. I'm always open to new ones – because sometimes you need a challenge, you need to try something different.

(BA): You're so right, people shouldn't be concerned about moving sectors. There's an astonishing amount of transferable values, approaches and learning that operates across the public sector. The experiences that you get from operating in different environments and roles are very helpful and can be of considerable benefit.

(TA): What would you say are the main skills you need for a long career in public finance?

(BA): Luck – never underestimate the right time, right place element. But in many ways, a long-term career in public finance is no different to a long-term career in any area – you will always set out to do the best you can. Sometimes it's more difficult than others, and sometimes there's some difficult learning you have to take on. But always try not to restrict yourself – the more you experience "different", the more you back yourself, the more confident you will become.

Although you're in the early stages of your career, it seems you've already done an awful lot. What sort of experiences do you want to have next?

(TA): The NHS is changing dramatically over the next year or so, with the move to integrated care systems – the whole landscape of how we commission, how we provide services, is changing. The next step is to look where my career fits in within a system landscape and see if there are finance roles available within the organisational structures. But I'm open to opportunities, and there are many roles that might come up in NHS England in areas other than finance.

For instance, I have a huge interest in digital transformation in the NHS. I had a two-month secondment at NHSX, which I really enjoyed. So if the opportunity does come up, I might explore other careers outside of finance, beyond the NHS as well – I would love to work in other public sector organisations – and I can bring that learning back to the NHS in the future. I want that broad range of experience, which is important to help make you a rounded finance professional.

(BA): And although your career may take you into other areas and functions that are not classically financial, because of your training you will always be able to look at it through a financial lens. You will, obviously, have other lenses as well as you develop, but you'll never lose that financial perspective, which is a spectacularly useful skill and capability to have.

With the changing landscape of the service, I expect it will be quite an exciting time for you.

However, we do need to ensure that we're developing our capability as well as our experiences in the areas of leadership, managerial techniques and so forth. Public sector organisations are certainly much more focused on doing that now than they were when I was starting out – management development and leadership development are far more accessible now.

(TA): Absolutely. I think it's essential now to get those softer skills, as well as the technical skills as you move further into your career. That support and leadership learning capability is easier to access nowadays. There are several mentoring schemes, for example, and sponsorship programmes, which I think are as essential to your career as your normal day job if you want to get to those senior leadership or board-level positions – as I hope to do. I would say though that leadership is about actions rather than positions, you can always make a difference regardless of your level.

But there are plenty of other opportunities outside of mentoring and sponsorship that are available via One NHS Finance that any junior finance staff within the NHS or healthcare in general can access.

(BA): That type of development opportunity is far more available and much better than I experienced back in in the day. The more NHS finance people who are able to benefit from that, the better.

(TA): There are so many resources that you can use not only for career development, but also to develop your finance skills within your trust or organisation as a whole, enabling us to work closer together and collaboratively use resource better. It's great for the future.

(BA): Even at my age, I'm still very proud to be part of the NHS finance family, as well as the wider public finance cadre. We have some of the most challenging roles in public sector finance, but we also have some of the most rewarding roles. When I finally hang my boots up, the key thing I can honestly say is I've never had a dull moment.

(TA): I completely agree with that. Working in the public sector, and in the NHS in particular, you do really feel fulfilled in your work. You have the opportunity to be involved in large-scale projects or initiatives that help communities, help patients or, if you're in other public sector organisations, help the community. And that's something I've always wanted in my career.

(BA): For me, the golden thread is a recognition in yourself that you played a part in something that has beneficially altered life for a group of people and that has made a difference. And that is pretty special.

## Career opportunities

If you are thinking about a career similar to Tahmid's are in a similar role and would like to develop your skills further, please find more details of CIPFA training courses by visiting **www.cipfa.org/training**

**Bob Alexander** is the acting chair of Imperial College Healthcare NHS Trust, a non-executive director (NED) at London Ambulance Service and Associate Director of Health and Integration at CIPFA.

**Tahmid Ahmed** has been a financial planning analyst at NHS England since July 2021. He passed his CIPFA qualifications in September 2021.


# A new look for a new era

**The same HFMA, a new look. Here to support you now and into the future.**

As we have done for over 70 years, the HFMA continues to look for new ways to best support the NHS and our members, now and into the future. We're introducing a new look to signal our commitment to this, making our content more digitally friendly and accessible to all.

Visit **hfma.to/newlook** to find out more


# Emergency response

**With the NHS facing a major backlog, ambulance services are also seeing rising demand for emergency call-outs and for 111 services. While there is no easy fix, the solution lies in delivering a system response. Steve Brown reports**


Acute hospitals are clearly at the centre of the NHS recovery programme, with a huge elective waiting list to manage. But, less obviously perhaps, ambulance services will also have a major role to play in eliminating the backlog.

'The ambulance sector is key to enabling the elective recovery,' says Claire Finn, director of finance at West Midlands Ambulance Service University NHS Foundation Trust. 'We won't be able to recover at all if patients are continuing to present at accident and emergency [in their current numbers], while hospitals are unable to get patients discharged.'

Although there is understandably a focus on hospitals, the solution is not just about running the acute sector faster. There must also be a focus on addressing upfront demand for acute services and the discharge process. And Ms Finn believes that the ambulance sector's contribution is sometimes overlooked. This can be through increasing the amount of treatment delivered on the scene – avoiding the need for conveyance – or it could be by directing or delivering patients directly to a more appropriate service.

## Pandemic challenges

Ambulance services have had their own challenges during the past 18 months as part of the response to Covid-19. They faced similar staffing challenges to those seen across the NHS as staff either caught the virus themselves – around one in five tested positive in the West Midlands trust – or were required to isolate because of close contact with the virus.

The trust puts a major premium on staff training – an approach reflected in its university trust status. As part of this it provides extensive training for paramedics through placements connected with Wolverhampton, Worcester, Birmingham, Staffordshire, Birmingham City and Coventry universities. At any one time, the trust can have up to 1,000 students working with it.

As a result, the trust had a head start when it had to rapidly increase workforce numbers during the pandemic. Some 400 net additional ambulance staff were taken on in different roles, including students who were deployed early and others working with non-emergency patient transport services (PTS).

It was not just staff on ambulances that were needed, but also call handlers too, for both emergency and 111 services.

While there were periods during 2020 when activity fell for the ambulance trust, demand has come flooding back.

'As I joined the trust in February this year, demand was rapidly growing for both 9s and 1s,' says Ms Finn. 'Pre-pandemic, 111 call volume was around 1.2 million a year – but [by the start of the year] it was at 1.8 million and is now heading for two million.' Despite the trust working to a block contract and so not having the financial commitment to expand, it needed to commit to recruitment.

'Our 111 service is so much more than a call centre,' she continues. 'The service has clinicians, pharmacists and mental health advisers, which are really difficult positions to recruit to given the shortages in these areas anyway. Our call handlers are band 3 roles, so not particularly highly paid, but are dealing with people either in crisis or frustrated at not having been able to access primary care. They are working in a consistently stressful environment, taking call after call, so retention is understandably difficult.'

The trust has merged its emergency and 111 centres with call handlers who are now trained to handle both types of call – giving much more flexibility on staffing arrangements and enabling better triage of calls.

## Recruitment push

In the ongoing recruitment plan, the trust looked to appoint some 300 call handlers and around 100 clinicians, and the recruitment programme is continuing. Amazingly, the trust is one of the few trusts not to use agency staff to fill vacancies – and has continued this throughout its Covid response, avoiding the accompanying premium costs.

On top of the increase in 111 traffic, the trust has been seeing 999 demand running at 10% higher than pre-Covid levels. And, like most ambulance services at the moment, West Midlands' biggest risk area relates to patient handover delays.

In October, services in England as a whole failed to meet the response time standard for the most urgent life-threatening incidents of getting to calls in an average of seven minutes and 90% of calls in 15 minutes – instead delivering a mean average response time of nine minutes 20 seconds. For category 2 emergency calls, the average response was nearly 54 minutes compared with the standard of 18 minutes and 40 minutes for 90% of calls.

Meanwhile, the service has had to deal with handover delays of up to 14 hours for some patients, despite a national standard of handing the patient over in 15 minutes. A clinical review undertaken by the Association of Ambulance Chief Executives on delayed handovers suggested that eight out of 10 of delays over 60 minutes were likely to inflict some level of harm on the patient.

The damage doesn't stop there; it also unnecessarily ties up the ambulance and its crew, keeping them off the road and potentially delaying a response for other patients. Lengthy handovers at hospital can also push paramedics into overtime, adding a financial cost too.

Ms Finn says the position will inevitably become more challenging over the winter months. But she says the solution lies in system-wide change. And she is clear that penalties on hospitals – which existed under pre-pandemic activity-based contracts – are not the answer. 'We can only resolve this by working together on the most appropriate model of care,' she says.

There are things that the ambulance trust can do. Its 'see and treat' and 'hear and treat' percentages are both up significantly, and in overall terms, its conveyance rates are down.

'We are ensuring we are treating many more patients in their own homes and we have a clinical validation team that can signpost patients to services other than A&E where appropriate,' Ms Finn says.

## Added complexity

The problem is complex. There is a role for more capacity in hospitals – involving more staff and beds and faster discharge. 'But the profile of patient demand is so different to pre-pandemic,' she says. 'That is both in terms of volume and, in some cases, complexity.'

The increased emergency demand is not only about Covid patients; the trust is also seeing the consequences of patients not accessing NHS services while social distancing restrictions were in place.

'Can primary care impact on the level of demand we are seeing for 111 and 999?' Ms Finn asks, acknowledging that general practice is also facing significant pressure. 'Or, if this is the new normal, we need to look at different ways to manage, otherwise we will continue to see this bottlenecking the whole system.'

Funding for social care is key to faster discharge from hospital for medically fit patients and freeing up much needed capacity, which can help reduce pressure and waits at the front door. But Ms Finn says that patient transport services also have a part to play.

But while West Midlands Ambulance Service provides PTS services for many systems across its region, not all ambulance

## Fleet concerns

West Midlands Ambulance Service has a fleet of more than 1,000 vehicles, including emergency and patient transport ambulances and specialist resources. No vehicle is older than five years. And Ms Finn says this relatively young fleet, along with a proactive recruitment process, meant the trust was in good shape heading into the pandemic and contributed to the trust's ability to meet all the national performance standards last year.

'Having a modern fleet keeps our maintenance and breakdowns fairly minimal,' she says, avoiding knock-on consequences in terms of response times and revenue costs. But she has concerns about being able to access sufficient capital resources to maintain this, while also helping to deliver the ambitions of the NHS net-zero commitment.

This year's £16.6m capital programme has been reduced to £15.6m to help the system stay within its capital envelope. 'When the acute and mental health providers have got such significant backlog maintenance or the need to invest in high priority clinical equipment, how do we prioritise the ambulance sector? The system is making a decision on behalf of the region about how much capital we get and

that will impact on our fleet replacement programme and our estates strategy,' she says. 'So, I would like to see the capital being dealt with differently going forward.'

The trust is also committed to carbon reduction, and has already almost halved carbon dioxide emissions by reducing the size of its estate from 149 sites to just 46. And it became the first trust in the country to introduce a fully 100% electric ambulance during 2020.

*Integrated emergency and urgent care call centre assessor (left) and on board an ambulance with paramedic staff (above)*

trusts are able to offer such a service.

Having the PTS capacity helped massively during the pandemic as the trust was able to deploy some of its PTS staff into its emergency and urgent care work to support the Covid response. But, says Ms Finn, PTS can only take on its full role in the recovery if the service is resourced to have the right capacity. In general, she is concerned that the potential for the ambulance service to support wider recovery is not reflected in current funding arrangements such as the Targeted Investment Fund, which is firmly focused on the acute sector.

Further, she says that proposals to have paramedics within primary care networks need to take into account the finite pool of paramedics that the NHS is drawing on – or recognise the time needed to increase the size of that pool.

## Integrated view

All of this points towards a bigger role for systems in taking a whole pathway view. However, as Ms Finn points out, integrated care systems are still in the evolution phase and ambulance trusts typically sit across multiple systems.

'In the West Midlands, we work across six systems, but we are hosted by just one – Black Country and West Birmingham,' she says. 'So how do we ensure there is a voice and a proper consideration of the ambulance sector across all six? We have some great ideas within the service, but how do we take this forward across systems with different priorities and challenges?'

She says the way system financial envelopes have been allocated creates challenges. For example, funding should have been allocated to ambulance trusts as part of the Mental Health Investment Standard (MHIS), especially because mental health issues have been a big part of the increase in demand over the past 18 months. But the growth funding for mental health services dictated by the MHIS doesn't necessarily get mirrored in ambulance trust contracts.

**"Our 111 service is so much more than a call centre. It has clinicians, pharmacists and mental health advisers – really difficult positions to recruit to"**

**Claire Finn, West Midlands Ambulance Service University NHSFT**

As with the whole NHS, the current temporary funding system based on block contracts – which has provided welcome stability during the pandemic – is masking the real underlying financial position for many organisations.

The £400m-turnover West Midland's trust delivered its required break-even for the first half of 2021/22, thanks to additional system funding of £2.2m and some additional funding for 111 services. But this also relied on £22m of non-recurrent income.

A full-year balanced position will need £55m of non-recurrent funds, taking into account additional costs for 111 and winter pressures. And that pressure will carry into next year when the current temporary financial regime comes to an end. 'How do we get this recurrently for 2022/23 when it will be very difficult to switch off any of the costs that we have got in the system?' Ms Finn asks.

Even a return to the pre-pandemic payment by results system would not fix this gap. If the trust had been paid for the first six months under the old regime, it would have received a further £8m (which wouldn't have included the 111 service) – well short of its gap in recurrent funding. And in any case, the service is not returning to the national tariff system.

'We need to reset the contract baseline,' says Ms Finn. 'Clearly, just like all organisations, we will have to deliver an efficiency requirement with a trajectory built in, but we can only do that if we have got certainty over the level of recurrent funding.'

The proposals for an aligned payment and incentive system allow for setting activity based on realistic projections rather than historical contract levels and also encourage contracts to be informed by costs and not price.

However, she acknowledges that affordability will inevitably play a part for the system commissioners – although there is an understanding within the finance community across the systems over the challenges that the trust is facing. 'The settlement for the next few years here will be key, along with a decision about how much funding can go into the ambulance sector,' she says.

The current ambulance handover delays outside hospitals are a symptom of an NHS under extreme pressure. The solutions are complex and will need to be across complete patient pathways. But there also needs to be a better understanding of the expanding role ambulance services can play as part of that system solution.

## Community Diagnostic Centres

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# Annual review 2020/21
## Reset and rebuild

## President's and Chief Executive's Report

**The business plan for the year to 30 June 2021 was set as a reset year for the HFMA, having pivoted the organisation in the last quarter of the year to 30 June 2020 to cope with the impact of Covid-19. The focus of that business plan was to maintain our volume of activities to support our members as much as we could and at the same time to ensure the organisation was financially sustainable by making a small surplus.**

We are delighted to be able to say that both objectives were achieved. The volume of activity and support to members was actually greater than ever in the last year. Financially the statutory accounts show a surplus of £348k for the year to 30 June 2021, compared to a deficit of £779k in the previous year to 30 June 2020. This is a most pleasing result and goes some way to rebuilding the reserves reduced in the previous year to a level of £3,954k at 30 June 2021.

The demand for outputs from our policy and technical team continued to be very high as did the requests for webinars and other online activities. Our free bitesize E learning modules, which are on the NHS ESR system, were accessed over 25,000 times. The number of people attending our virtual events was considerably higher than used to attend face-to-face events. The reach across the NHS, as a result, was far greater than ever before.

If we did not know it already, we were reminded how resilient and supportive the NHS finance function is. We received numerous messages of support and useful suggestions as to how the HFMA could assist and support the finance community across the NHS. As a result 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 the HFMA volunteers and membership have put into the association have ensured we have survived and been able to move forward with confidence.

By the membership providing this support, the association was also able to provide a significant increase in public benefit as evidenced by, for example, the levels of social media traffic and downloads of material over the last year.

When we develop our business plan each year, we set some key performance indicators, which we measure ourselves against each year. These show that at the end of 30 June 2021 we had reached a record 17,396 members and supported them and others through:

- 336,900 hours of CPD provided during the year
- 109 regional and national events including webinars
- 36 briefings and publications.

We ask attendees and users of all our activities to give feedback and over the last year we achieved an amazing 96% good or excellent on events and 96% from everyone who undertook our bitesize e-learning. We are very proud of this feedback.

During the year to 30 June 2021, we also continued to host, work alongside and support One NHS Finance with the delivery of its programme of work in England, which has expanded considerably to encompass Future-Focused Finance, the National Finance Academy and the Finance Innovation Forum. We are proud to be a part of this exciting and developing set of programmes.

At the beginning of the year, the trustees recognised that the future was very uncertain and therefore, rather than set the new three-year strategy from 1 July 2020, it was decided to have two years of reset to 30 June 2022, 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 2022 to 30 June 2025.

We would like to take this opportunity to thank our friends on the corporate partner programme, 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.

Our theme for the period of the pandemic has been *Taking pride in our future*. We have never been prouder to be supporting our members working in the NHS through this hugely challenging time. They have demonstrated resilience, professionalism and sheer guts in keeping the NHS running over this last year.

There's always more to do, but it is clear that the future looks very different post-pandemic to what it was pre-pandemic. At the HFMA we will continue to work hard to support our members as the NHS moves forward and we will work hard to help ensure that we keep the best of what we've learnt over the last year.

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

# Annual review 2020/21

# Total number of HFMA members:

**17,396**

a **4.4%** increase on 2019/20

(2019/20 16,666)

## Highlights

**The new home of HFMA**
HFMA House, 4 Broad Plain, was purchased

Reached
**706,086**
**total website page views**

**Record number of CPD hours delivered**
**336,900**

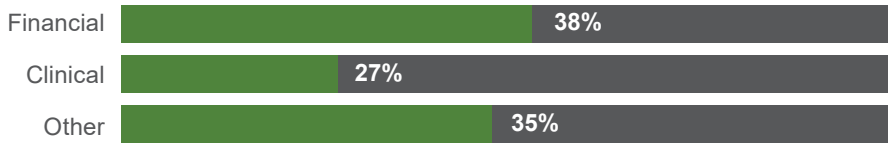
## HFMA Qualifications

**621**
learners enrolled onto qualifications
**+14%** from 2019/20

**151**
learners completed a qualification

**6**
learners completed their MBA with BPP University

**Breakdown of learners**




## Financial Management Training

In September 2019, eight new trainees joined the Financial 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

Produced **36 new publications**

**Responded to 15** consultation papers

Published **11 new podcast episodes**

## Skills Development Network

**1,900**
**CPD hours**
**371**

**The South West** Skills Development Network delivered 30 events as part of its 2020/21 programme, welcoming 371 delegates and delivering over 1,900 CPD hours to the region.

**1,800**
**CPD hours**
**477**

**The West Midlands** Skills Development Network delivered 35 events as part of its 2020/21 programme, welcoming 477 delegates and delivering over 1,800 CPD hours to the region.

**1,300**
**CPD hours**
**290**

In the **South Central region**, a total of 22 events were delivered as part of the 2020/21 programme, reaching over 290 delegates and delivering over 1,300 CPD hours.

**1,000**
**CPD hours**
**431**

In addition to this the SDN ran 8 joint events as part of the 2020/21 programme, welcoming 431 delegates and delivering over 1,000 CPD hours.

## Commercial sponsorship

Supported by **19** corporate partners

# Learning and development

**96% good or excellent feedback** on events received.

Provided **336,900 hours** of CPD.

Held **109 regional and national events** and webinars.

**Published 36 briefings** and publications.

Hosted **40 webinars**.

Welcomed **4,668** webinar attendees.

# Future-Focused Finance

During 2020/21 the HFMA continued to host the Future-Focused Finance (FFF) programme, which saw large increases in network membership and organisations gaining accreditation. We also supported the development of the new strategy and programmes under the One NHS Finance initiative following the national engagement campaign. The new strategy sets out an ambitious vision for the future and some key priorities for the next five years.

# HFMA bitesize

**5** new intermediate courses released.

Out of these all **5** intermediate courses were made available free of charge to the NHS. **24,654** courses have been accessed since they were released on 31 March 2020. **20,218** of these were completed between July 2020 and June 2021.

**28,538** short courses assigned to learners and **5,409** courses completed.

**670** learners completed their introductory award in healthcare finance.

# Annual conference

- HFMA president Caroline Clarke continued her theme *Taking pride in our future*. Due to the restrictions of the pandemic, Caroline continued her presidency and carried over her theme from 2019, becoming the first ever President to undertake a two-year term of office.
- Held as the first virtual annual conference, hosted from 110 Rochester Row and streamed out to a live audience, it extended over 12 days and attracted over 3,000 delegates across this period.
- Baroness Floella Benjamin closed the HFMA annual conference 2020.

# Branches

The **South Central** branch annual conference and awards welcomed 343 delegates to their virtual annual conference in September 2020.

In September 2020, 157 delegates attended the **South West** branch annual conference. The conference received 100% excellent/good feedback.

The **West Midlands** branch annual conference ran in October 2020 as a virtual event. Over 560 delegates attended.

The **Wales** branch welcomed 250 delegates over their 5 day virtual annual conference in September 2020. However, on average around 110 logged in each day, providing 1,925 CPD hours across the 5 days.

The **London** branch hosted a number of events throughout the year delivering over 170 CPD hours.

133 delegates attended the **Scotland** branch annual conference in October 2020 as a virtual event.

The **East Midlands** branch held 3 technical events, all successfully hosted online.

The **Eastern** branch welcomed 300 virtual delegates to their first annual conference held in partnership with FFF and SDN and held 11 virtual events delivering 5,124 CPD hours.

The **Kent**, **Surrey** and **Sussex** branch held their first virtual conference in October 2020 and welcomed 179 delegates online, providing 1,163 CPD hours.

The **Northern Ireland** branch continues to deliver pertinent and well attended CPD events and welcomed 274 delegates to their annual conference in November 2020.

The **North West, Northern, and Yorkshire and Humber** branches ran a number of online events during the year.

The **Yorkshire and Humber** held 2 virtual events for 103 finance leaders and 4 virtual ‘bitesize’ events.

# Policy and technical

**During 2020/21 HFMA's policy and technical team produced 36 new briefings, updated a further 22 and submitted 15 responses to consultation documents issued by stakeholders.**

Our briefings covered a range of subjects aimed at supporting members as they go about their work. The topics covered included population health management, costing, the mental health investment standard, accounting for NHS charities, the external audit market, as well as our usual suite of year-end related outputs. We also published a paper on the post Covid-19 NHS financial regime, which considered the changes needed to make the best use of scarce NHS resources and a range of briefings to support the development of integrated care systems.

We also produced a number of timely briefings summarising guidance produced by NHS England and NHS Improvement and others. Our range of 'maps' continued to be popular, with the NHS efficiency, NHS corporate governance and Covid-19 maps being regularly updated during the year. We added a mental health guidance and resources map to the range and have plans for further guidance maps as we know members welcome being able to easily find support on specific topics.

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. We published the *NHS finance function in 2019* report in partnership with FFF and the Skills Development Network. We also produced a number of briefings with our corporate partners covering issues such as improving data quality in the NHS and the use of digital workers.

During 2019/20, the policy and technical team undertook a number of income-generating projects to support the finances of the association. This included the production of draft system financial governance documentation for NHS England and NHS Improvement and guidance on NHS finance for Innovate UK. We are also now providing secretariat and technical support to the Association of Ambulance Chief Executive's Finance Directors' Group.

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 June 2021 moved online, welcomed 1,000 delegates and focused on the overarching theme *Reflect and reset,* which sought to capture learning from the pandemic. The programme was designed as an online festival of learning, with tickets sold on an organisational basis, meaning one ticket allowed access for the whole finance team. This approach was well received by attendees. Keynote addresses from speakers such as Professor Sir Chris Ham, Amanda Pritchard and Paralympian Ellie Simmonds were blended with detailed NHS case studies and an examination of health inequalities via a panel of senior NHS finance leaders and clinicians.

As well as a move to online events in response to the pandemic, September saw the official launch of the HFMA Hub, a refresh of the HFMA networks and previous faculty offering. The first event in the programme year was the professional development summit. This was aimed at finance professionals from provider and commissioner organisations and brought together several of the HFMA Hub networks, including the new System Finance Network. This new design and way of delivering content allowed our members to still keep on top of their CPD and learning despite new ways of working, with many still working from home at this time.

This theme of accessing high-quality online content continued with the November commissioning forum focusing on delivering better care for major health conditions, and the February integration summit focusing on integrated care systems and the progress towards national coverage by April 2021. We also launched a new finance managers' forum in February. The forum provided a mixture of policy updates and technical support looking at the skills required for the finance manager role and for career progression.

The highlight of the year for the Mental Health Network was the annual mental health conference in March 2021. 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, and the event closed with a moving session from Jax Kennedy, a patient speaker discussing how being granted a personal health budget has provided her with access to her beloved service dog Kingston, who also joined in with the session!

The networks continued to work closely with those in senior finance and leadership roles in the NHS this year. At the online forum for finance directors and chief finance officers in January 2021 Siva Anandaciva, chief analyst, The King's Fund, looked back at some of the key health policies and reviewed some of the successes, innovations and incredible leadership the NHS saw in the memorable year of 2020. Julian Kelly, chief financial officer at NHS England and NHS Improvement, also provided an update and outlined the key priorities for finance leaders in the year ahead. The CEO and Leadership Network continues to deliver high-quality content, including an update from Ted Baker, chief inspector of hospitals at the Care Quality Commission alongside a fascinating Q&A style session with Professor Yvonne Doyle, medical director and director for health protection, Public Health England at our 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, including specific events for NHS chairs and audit committees. The content for the network is also shaped and influenced by the 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 successfully moved its introduction to costing, value masterclass and costing together events online, and held two costing conferences in November 2020 and April 2021, with hundreds of virtual delegates attending.

The Institute also welcomed a number of new associate partners throughout the year including the Picker Institute, King's Health Partners and the Federation for Informatics Professionals in Health and Social Care. The Institute works collaboratively with its associate partners on research, best practice sharing and thought leadership.

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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# Future vision

**New HFMA president Owen Harkin says the health and care sector must focus on a range of priorities – and asks how positive developments made during the pandemic can be best used in the aftermath of Covid. Seamus Ward reports**

Besides the considerable issue of caring for patients with Covid, the priorities for the health service over the next year will undoubtedly include integration and reducing waiting lists. It would seem timely, then, that new HFMA president Owen Harkin has plenty of experience of both of these issues.

Mr Harkin, who is director of finance and estates, and deputy chief executive of the Northern Health and Social Care Trust in Northern Ireland, says his presidential theme, *Reimagining the future*, aims to reflect current issues facing health and care across the UK. But it also highlights the opportunities to adopt permanently the positive steps taken during the pandemic, and think again about how future health and care could look.

## Three priorities

There are three parts to the theme – the short term (getting over the Covid crisis and recovery); longer term changes to the NHS; and the future of the HFMA.

In the short term, there are many challenges. The health service was running hot well before Covid, even more so in Northern Ireland where waiting times were, and remain, the longest in the UK. Mr Harkin says the pandemic hasn't fully gone away, and the need to continue to care for Covid patients while switching services back on to tackle waiting lists has been challenging for staff.

He adds: 'Winter is coming, and naturally we are asking how we will get through it. How can we stabilise the system to get ourselves through the next few months, and then look to move forward from there?'

Though the system locally has seen financial support through Covid, as with elsewhere, this is a short-term fix to help the service through the pandemic. There is a need for longer-term reviews of finance and workforce planning in order to address the significant staff shortages in medical, nursing and social care staff that exist across the UK. Social care, in particular, needs a clear strategy to build a sustainable and robust workforce across all service areas, including in independent sector care homes and domiciliary care.

'We must take a longer-term strategic view to give us some confidence that we will have sufficient numbers in our workforce for the future, and we must build in sufficient flexibility to deal with issues that may arise, such as a future pandemic,' he says.

Financial regimes could change as the threat of the pandemic recedes, Mr Harkin adds. 'I think we might do things differently, back to more of a push to greater real productivity and not just efficiency savings. Are we delivering services at a system level in the best way we possibly can? If we're not funded to the levels we think we need, then we must have an honest conversation on the services the public should expect. That would be a more proactive approach; engaging the public and encouraging them to take more control over their health.'

During the pandemic, the focus has been on delivering services rather than, as in recent years, the close monitoring of finances. 'Finance teams had a reputation for control and grip, but now the challenge will be to try to get that corporate grip back in organisations. Where money hasn't been such an issue for the past two years, it's also going to become about waiting lists and a performance focus – and rightly so – especially in the run-up to the next general election.

'Finance teams in the coming months will have a key role to play in maintaining credibility, control, and confidence. We must make sure we are as efficient as we can be, making sure we are not running too hot, while demonstrating efficiency and effectiveness to aid the case for the resources required, and prove that we will use them as effectively as we possibly can.'

Covid changed a lot, he says, and services must think about how the pandemic could alter their long-term development. 'We have to look at what went well – and a lot did go well. A lot of barriers were torn down last year, between professions, divisions and sectors.

'They fell away because they had to,' Mr Harkin adds. 'I think there's an opportunity to maintain that collaborative working, which we had at all levels, to deliver the best service we can to our local populations. That's why we are here.

'It should not be about professional priorities, but engaging to deliver the best possible care. It might mean us being more flexible about the delivery of services, or asking if people are working to the top of their skills and professional accreditation with associated flexibility in skill mix, given the realities of workforce challenges.'

**"Finance teams will have a key role to play in maintaining credibility, control and confidence. We must make sure we are as efficient as we can be"**
**Owen Harkin**

## Integration gains

Health and social care have been integrated for the best part of 50 years in Northern Ireland, but Mr Harkin insists integration offers opportunities to work across organisations as well as within them. For example, clinicians could work across different organisations and across secondary and primary care. Finance staff have a part to play in facilitating these flexibilities to support the delivery of services.

'Throughout Covid, finance staff have really stepped up, delivering with colleagues in areas such as personal protective equipment (PPE) procurement and distribution, fit testing, and oxygen monitoring, maintaining financial services while many worked remotely,' he says.

'Finance staff have proven ability in solving problems quickly while establishing robust processes and monitoring. Finance teams' credibility has increased during Covid, and we must use that engagement with clinicians in a positive way in the future.'

THEODORE WOOD

**"Finance teams' credibility has increased during Covid, and we must use that engagement with clinicians in a positive way in the future"**
**Owen Harkin**

He is convinced each part of the UK has something to teach health and care services in the other nations, and the HFMA has a key role in bringing them together.

An initial meeting of senior finance staff from the devolved nations took place in November, and Mr Harkin hopes this will develop into a useful forum for all parts of the UK.

## HFMA strategy focus

The third part of his theme focuses on the HFMA, which will release a new three-year strategy during his term. He says the association has come through a difficult two years, thanks to the leadership of 2020 and 2021 president Caroline Clarke and chief executive Mark Knight. But now is a good time to review the strategy on the association's activities, including research and education.

Mr Harkin has been working on a sub-committee looking at the association's qualifications, and its recommendation, which will take effect in the January intake, will recognise the integration agenda.

He is also keen that the HFMA supports colleagues through the demise of clinical commissioning groups.

'We can support our colleagues as they face the organisational challenges of the move to integrated care systems, helping them to prepare for the change, help with interviews, help them understand the new model,' he says.

The HFMA is well respected for its research on financial challenges, the financing of the NHS, and health and social care integration, for example, and Mr Harkin would like to see the association taking a leading role in health and care, speaking up where appropriate.

'We have an opportunity to engage with those in power – NHS England and NHS Improvement and the departments of health – to influence their thinking,' he says.

'We need to be willing, when the occasion is right, to speak truth to power. I would like to develop our role as influencers – up and down. Within the HFMA membership, we have a massive network of NHS finance experts. We need to try to harness that and use it.'

As he embarks on his year as president, Mr Harkin recognises the personal challenge presented by being largely based in the Northern Irish system – but it is a challenge he is willing to face, knowing that he can rely on the support of the HFMA team and fellow trustees from the NHS in England, Scotland and Wales.

He is also grateful for the support of his own trust and the directors of finance across Northern Ireland.

'I am looking forward to it. It's a massive honour, especially because I will be only the second person from Northern Ireland to be HFMA president,' concludes Mr Harkin.

'I believe the HFMA is about the members and the branches, and that's why I want to do my bit and get to as many branch conferences as I possibly can.'

## Public sector career

'I joined health and social services in 1988 as it was the first place that offered me a job,' says Owen Harkin with a chuckle.

He had applied for a number of vacancies, having recently graduated from the University of Ulster. 'I wanted to be in something on the management accounting side of things. I wanted to be CIMA as I found management accounting to be more interesting. I loved working with budget-holders regularly – nurse managers, social care managers – and forecasting.

'The health service has been very good to me. I was supported through day release to complete my accountancy qualification (CIMA) in two years. I owe the health service for that. And I met my wife in the health service.'

Mr Harkin began his career in the finance department of the Western Health and Social Services Board in Derry, and, over the following 16 years, progressed through a series of finance roles in the health service across Northern Ireland.

He had a six-year spell as a chief finance officer in the local education sector from 2004 to 2010. But he was keen to return to the health service, and joined the Health and Social Care Board – the commissioner for the whole of Northern Ireland – in 2010 as assistant director of finance working with Paul Cummings. Mr Cummings was HFMA chair in 2003. Mr Harkin's time at the board included a year as acting director of finance.

'When I was in education, I missed health and I missed the HFMA. Education didn't have the same network, though I organised some regional finance training and used some of the HFMA's contacts. The first thing I did when I went back into health was to rejoin the HFMA.'

Mr Harkin took up his current position as director of finance and estates with Northern Health and Social Care Trust in 2015, and then assumed the role of deputy chief executive in April 2020.

This coincided with the pandemic and his lead role in procuring PPE and, more recently, leading the trust vaccination programme.

The deputy chief executive role has been an 'amazing experience', he says, working across the entire organisation. 'I believe in change and stretching yourself – that's why I took on the estates function then the deputy chief executive role. It is an honour to be in such a lead role in an organisation with an amazing range of talented and committed professionals, all working to provide the best possible care to the most vulnerable in our community.'

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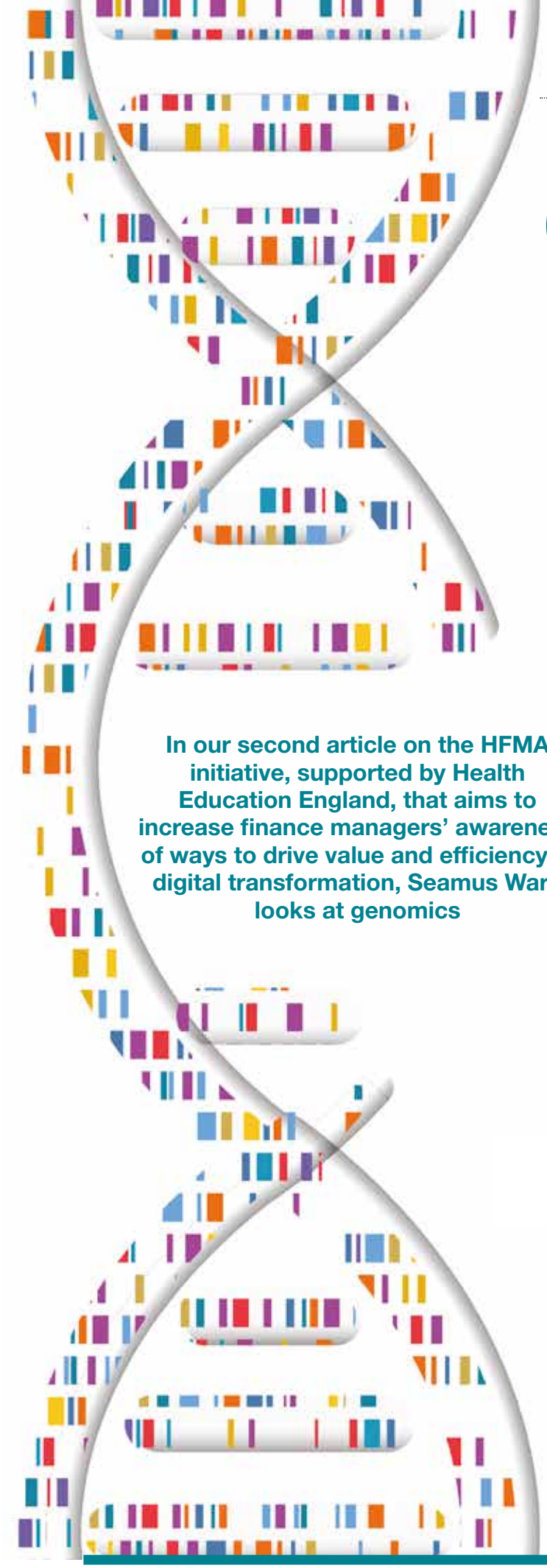

# GENOME MAP

**In our second article on the HFMA initiative, supported by Health Education England, that aims to increase finance managers' awareness of ways to drive value and efficiency in digital transformation, Seamus Ward looks at genomics**

The science of genomics is having an increasing influence on health and wellbeing. Whether it be identifying new Covid-19 variants, or adverts offering tests to discover hidden genetic abnormalities, the uses of genomics are more widely known. Its profile has also been raised in the NHS, where the genomics service has developed rapidly in recent years, and is pushing into mainstream medicine.

The *Topol review* in 2019 identified genomics as one of three major technologies that would lead to digital transformation of the NHS, alongside robotics and AI, and digital medicine. The review said the 100,000 Genomes Project (*see box overleaf*) would lead to widespread use of genomics across the health service. As such, genomics forms part of the HFMA's project, supported by Health Education England, to raise awareness among finance staff of how digital technologies can transform services and drive value and efficiency (**hfma.to/mof**).

The development of genomics will have an impact on diagnosis, ensuring problems are discovered sooner, leading to earlier intervention, less anguish for the patient and their families, and possibly avoiding costs later. Genomics can also affect treatment and its costs, through the developing field of pharmacogenomics.

In pharmacogenomics, a patient's genome is analysed for genetic markers that could, for example, highlight a predisposition to potential side effects of medication, allowing clinicians to adjust doses and ensure more efficient targeting of drugs.

## Genomics England

In 2013, the government launched Genomics England, led by Chris Wigley, 'to unlock the power of DNA' through the 100,000 Genomes Project, research and by working with the NHS to scale up the NHS Genomics Service. Genomics England is funded mainly by the National Institute for Health Research and NHS England.

As the NHS service has scaled up, genomic testing for a range of rare and inherited diseases, as well as cancers, has been available since 2018. The service will be developed incrementally, becoming more mainstream. But despite the work of both services, and the role it has played in tackling Covid-19, polls have found that the public is unfamiliar with genomics. Trust is also an issue, with people concerned about how their data is being used, who is using it, and who stands to benefit. Mr Wigley says Genomics England is determined to increase awareness and understanding, and has introduced public dialogue sessions and a podcast, *The G Word*.

Undoubtedly, the NHS would not be making its venture into genomics without the pace of change in genomic testing seen over recent decades. At the turn of the century, genome sequencing was too slow and too expensive to be used in a clinical setting, but since 2005 new techniques have been introduced. Not only have these sped up the process to a matter of days, but also reduced costs.

The US National Human Genome Research Institute has tracked the

SHUTTERSTOCK

## Is genomics genetics?

The short answer is no, though there are obvious crossovers.

Genetics is the study of genes, a family history of traits and conditions that are passed from generation to generation.

Generally, genetic testing has focused on individual parts of a person's genetic material. Genomics, however, is the detailed study of all a person's genes, or their whole genome. It looks at how genes interact with each other, and with the environment, and includes the study of complex diseases such as diabetes and cancers.

In genomics, a person's DNA is sequenced, revealing the order of its four building blocks or base nucleotides, denoted by the letters G, C, A and T.

A human genome has about three billion nucleotides, and test samples are compared with a reference genome to pinpoint abnormalities.

The sequence allows scientists to determine, for example, which stretches of DNA contain genes, and which include information that turns genes on or off. The latter are protein-coding sections (exomes) and are important in diagnosis – the exome represents less than 2% of the genome, but contains most of the known disease-causing variants.

cost of sequencing a genome, which has fallen from $100m in 2000 to less than $1,000 in 2021. Genomics England says a whole genome can now be sequenced for less than £1,000.

The NHS Genomics Medicine Service (GMS) is nationally funded by NHS England (about £400m a year), which commissions a list of genomic tests, outlined in the *National genomic test directory.* It is supported by a network of seven NHS Genomic Laboratory Hubs (GLHs). The East GLH, like its six counterparts across the country, offers tests from the directory for rare and inherited disease and cancers, and specialist testing nationally in neurology and endocrinology.

East GLH clinical operations director Amanda Clarkson says the aim of the national service is to improve patient access to genomic testing and support the development of more personalised healthcare.

The GLH has three sites and is responsible for the East of England and East Midlands, covering a population of 8.3 million and 29 NHS hospital trusts. Currently, the East GLH carries out around 1,800 rare disease tests and 1,400 cancer tests across its sites each week and these figures are set to increase as new tests are being added.

The genomics testing process is much the same as any other diagnostic test. The patient's doctor – most often a hospital doctor – requests a test, and takes the relevant sample. The most appropriate test (or tests) is then performed by the laboratory team and the results analysed by a clinical scientist. A report is sent back to the referring doctor, who can then take action. Specialist tests not undertaken by East GLH are sent to the appropriate laboratory as part of the GMS.

In complex cases, multidisciplinary teams meet to discuss the test result and implications for treatment with the referring doctor before the report is finalised. This streamlines the reporting process, ensuring intervention can be made as soon as possible.

'Some tests have been around for a long time, so clinicians know exactly which tests to order,' Dr Clarkson says. 'But for some of the newer tests, such as whole genome sequencing, we engage with clinicians in advance of those tests coming on board to explain how to order the tests and the appropriate eligibility criteria.'

Whole genome sequencing can replace a series of tests, making it better for patients, more effective and potentially more efficient and cost-effective. Knowledge of specific parts of the genome can also help avoid an adverse drug reaction. 'With pharmacogenetics, if you give the most effective medication, you reduce the likelihood of an adverse drug reaction, which again is more cost-effective,' adds Dr Clarkson.

New tests can be added to the national test directory. In pharmacogenetics, in the past 12 months NHS England and NHS Improvement commissioned DYPD testing. The test highlights genetic variants that lead to deficiencies in the DYPD enzyme. Deficiencies in this enzyme can cause greater side effects in cancer patients who are taking common chemotherapy drugs. Armed with the genomic test result, dosing can be adjusted.

The East GLH began offering the test in April. 'We have good uptake for this service, and on average perform 500 tests a month. There are more and more pharmacogenetic tests, helping to develop effective, safe medication tailored to the patient's genetic make-up,' Dr Clarkson adds.

There have been some delays in developing the service, Dr Clarkson says, many of which are due to the Covid pandemic, though, as always in the NHS, funding can be less than hoped for.

She continues: 'This is a huge transformation programme, setting up new pathways and networks, discussing funding, and making sure it all happens to enable us to set up the infrastructure and provide the throughput in genomic testing. In this scale of service development, you have challenges and opportunities.'

Demand is rising, and the GLH would like to raise its capacity, especially at its main lab at Cambridge University Hospitals NHS Foundation Trust. More staff would be needed – Dr Clarkson says the Cambridge site has about 160 staff currently. 'We are recruiting all the time. Nationally, there is a shortage of experienced clinical scientists, and the service is examining ways of improving that situation.'

Genomics is a developing area for the NHS and new tests are added to the directory regularly. There are limiting factors – principally capital and staff – but increasingly a patient's DNA will be part of clinicians' toolkit as they seek to provide more efficient, high-quality healthcare.

## 100,000 Genomes Project

The project was created to sequence 100,000 genomes from NHS patients affected by rare diseases or cancers, and create a genomics medicine service for the NHS. Linking sequence data with diagnosis backs medical research, and has helped kick-start a UK genomics industry.

The project was announced in 2012, and Genomics England – a company wholly owned and funded by the Department of Health and Social Care – was set up the next year to deliver it. The 100,000th sequence was achieved in December 2018.

Scientists have been sifting through the information and have found actionable findings in up to one in four rare disease patients, while 50% of cancer cases analysed had the potential for a therapy or clinical trial.

There were big challenges – dealing with the volumes of data generated by sequencing, comparison with a reference genome, and determining the importance and meaning of differences highlighted.

Genomics England says the raw data from one genome is 200GB, close to a laptop's capacity. Comparison with a reference genome would generate more data still.

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# Greening up

**The focus on reducing the NHS carbon footprint will sharpen over the coming months as the country continues to move towards net zero. An HFMA roundtable, in association with Lexmark, heard how it will affect NHS finance, and how finance managers can support the sustainability agenda. Seamus Ward reports**

HFMA ROUND TABLE

Climate change is rarely out of the news, and this autumn was no exception with the United Nations climate change conference, COP26, taking place in Glasgow. Accounting for 4% to 5% of the country's carbon footprint, the NHS in England will play a key role in meeting the UK goal of becoming net zero by 2050.

The health service is keen to step up, not just because of its carbon footprint, but also because a deteriorating climate can lead to poorer population health.

NHS social value guidance for trusts is expected, and from April 2022 NHS organisations will be required to take greater account of social value when buying goods and services. A sustainability framework is being developed, with input from suppliers, so that by 2030 the NHS will stop contracting with those that have not met minimum expectations in achieving carbon neutrality.

The *Delivering a net zero NHS* report published last October commits to reducing the NHS carbon footprint (emissions directly controlled by the NHS) to net zero by 2040, with the aim of achieving an 80% reduction by 2028-2032. The health service plans to reduce the indirect emissions from its supply chain that it can influence (the NHS carbon footprint plus) to net zero by 2045, aiming for an 80% cut by 2036-2039.

## Staff focus

Not only do finance staff need to be aware of the policy changes, as it will have an impact on their work with procurement colleagues, but some finance directors are board-level sustainability leads, playing an active role in delivering their organisation's environmental ambitions. The finance role was examined at a recent HFMA roundtable, *How does the NHS finance function embed sustainability in decision-making*, in association with global imaging firm Lexmark. It gathered together senior NHS finance and procurement staff, as well as environmental experts.

Preeya Bailie, director of procurement, transformation and commercial delivery for NHS England and NHS Improvement, told the roundtable that while the health service often talks about sustainability, central government refers to social value. The latter has a wider definition, and includes local employment, support for local businesses and Covid recovery, as well as reducing the impact of climate change.

Roundtable chair Dave Stacey, who is deputy chief executive and chief finance officer at Torbay and South Devon NHS Foundation Trust, said the NHS has some way to go in terms of embedding a clear definition of social value, adding a challenge to the wider community to think this through. 'We all know the wider determinants of health – quality of housing, education, air – but we never really talk about social value day to day,' he said.

Ms Bailie said central government had defined five determinants of social value (see box overleaf), which she and her

## Participants

- Preeya Bailie, NHS England and NHS Improvement
- James Dixon, Newcastle upon Tyne Hospitals NHS Foundation Trust
- Aaron Gillott, University Hospitals of Derby and Burton NHS Foundation Trust
- Nigel Gloudon, Cheshire and Merseyside ICS
- Neil Hind, NHS England and NHS Improvement/Greater Manchester Health and Social Care Partnership
- Rob Knott, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust
- Ged Murphy, East Cheshire NHS Trust
- Lee Outhwaite, Chesterfield Royal Hospital NHS Foundation Trust
- David Stacey (chair), Torbay and South Devon NHS Foundation Trust
- Sylvie Thomas, Lexmark
- Alan Wain, NHS Supply Chain
- Louise Wall, healthcare industry consultant

team have been promoting to the NHS ahead of the requirement to include social value in all tenders from 1 April 2022.

For the NHS, much of the delivery of social value will be about good procurement practice, she said. NHS England and NHS Improvement have been adding at least a 10% weighting for social value on all its tenders since April 2021. 'We went with 10% because it's significant and starts to move and change markets,' she said.

## Social value weighting

All central government procurements have been required to use the 10% social value weighting since January this year. Ms Bailie's team has held discussions with NHS heads of procurement, not just about how to start building the 10% weighting into bid evaluations, but also how to think about specifications in a more sustainable way.

'We have a long way to go. My only nervousness is that we go to the other extreme and start to put a lot of burden on suppliers,' Ms Bailie said. 'Some NHS tenders coming out are asking for environmental impact assessments and a lot of other things – if we are not consistent in the way we ask for that information, it will start to put up costs for suppliers, which then comes back to the NHS.'

HFMA ROUND TABLE

However, from the supplier perspective there were differences between national aspirations and day-to-day reality in the procurement process, according to Louise Wall, a healthcare industry consultant who is working with Lexmark.

'Currently, a tender lands in the inbox, and it has at best 5% weighting on innovation and anything remotely to do with sustainability. As much as there is this fantastic vision at national level, at the moment that isn't cascading down to the day-to-day decision-making. I believe this comes back to the challenge with annual financial targets and not necessarily focusing on value-based procurement and social value.

'We've got to start looking at things with a longer-term perspective to successfully build in sustainability as a core requirement.'

Neil Hind, NHS England and NHS Improvement sustainable procurement lead in the North West of England, asked if the NHS was ambitious enough aiming for 10% weighting for social value when in local authority tenders it is often 20% or 30%.

Suppliers are keen to support sustainability, he said. 'They are saying we need to challenge them more. We need to put it in the tender spec and make them evidence it..'

Ms Bailie said there was a balance to be struck, and the NHS must understand which markets are ready to push forward with the sustainability agenda. Medicines suppliers are already taking significant steps, she said, but others are not yet ready.

**"We went with the 10% social value weighting because it's significant and starts to move and change markets"**

**Preeya Bailie**

## Social value model

At the end of 2020, the government set out five determinants of social value.

- **Theme 1: Covid-19 recovery** Help local communities to manage and recover from the impact of Covid-19
- **Theme 2**: **tackling economic inequality** Create new businesses, new jobs and new skills. Increase supply chain resilience and capacity
- **Theme 3: fighting climate change** Effective stewardship of the environment
- **Theme 4: equal opportunity** Reduce the disability employment gap and tackle workforce inequality
- **Theme 5: wellbeing** Improve health and wellbeing

Alan Wain, formerly of NHS Supply Chain, said the themes distil down to 140 KPIs that can be measured across a procurement exercise, though only a selection of the KPIs would be included in any one exercise. The metrics will be different for a global market compared with a local one involving SMEs, he said.

'In social value assessment criteria, it's not a case of one size fits all. We've got to ask which are the most important aspects of social value to each category of spend. It will vary. I advise limiting the number of KPIs you put into any one procurement, so it has the most impact and drives the behaviours of suppliers rather than being a tick-box exercise.'

He also urged the NHS to develop a database of suppliers' environmental credentials, accessible to all NHS bodies, providing the same information to keep the bureaucratic burden and costs down.

Adjusting the procurement process by introducing pre-selection of potential suppliers can boost the achievement of social value, suggested Sylvie Thomas, Lexmark's head of sustainability policies, corporate and social responsibility, and circular economy. 'Pre-selection can help you move beyond 10%, which can be your minimum level,' she added.

Rob Knott, chief commercial officer, digital, at Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust, took up the theme, sharing his experience of pre-tender engagement while working on the London Olympics. 'We hardwired social value criteria that included a range of sustainability and environmental targets, and also the creation of jobs and employment of local people,' he said.

A number of large facilities management and construction companies were keen to bid for these long-term contracts and, as a result of the social value criteria, two decided to create unique social enterprise subsidiaries to win the tenders. 'It requires break-through thinking,' he said. 'If we run our tenders in the same old way, we shouldn't be too shocked when we get the same old answers.

'Through a pre-procurement market engagement process, we can share with the market the outcomes we want to achieve, and we can understand what the market is capable of delivering. And then we must back up our commitment with funding.'

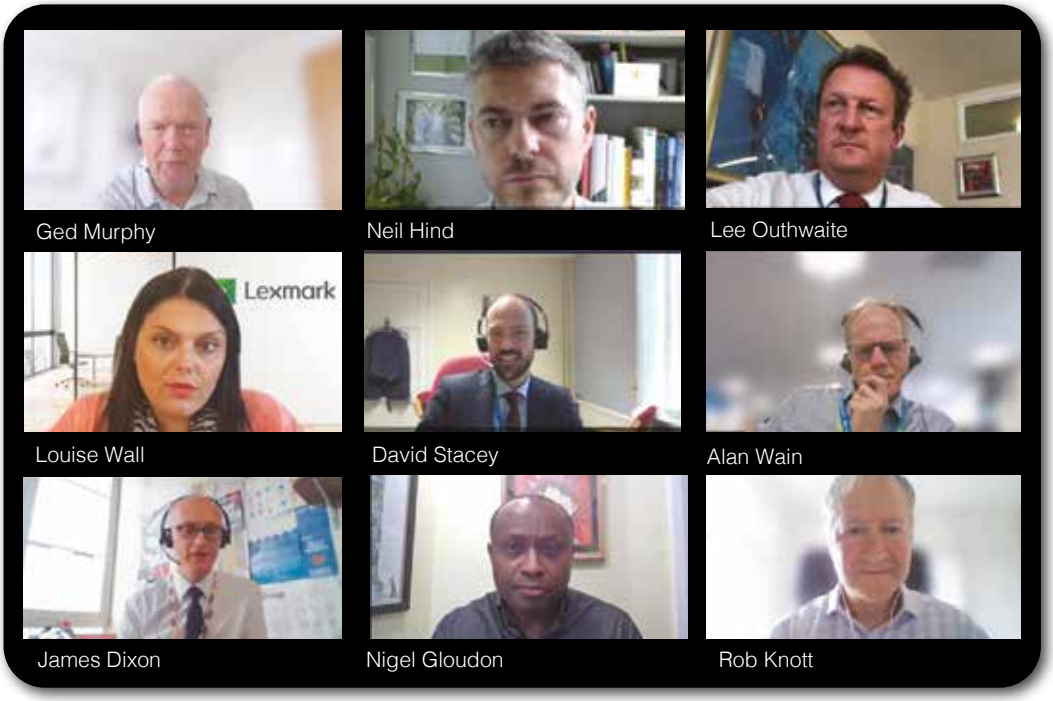
## Balancing priorities

Finance directors questioned how the service can square the circle of cost reduction, quality improvements and being sustainable. Some said sustainability can feel optional, especially when the regulatory focus will be on elective waiting list recovery and cost improvement programmes (CIPs).

To address this, regulation had to be aligned with the environmental aspirations. Nigel Gloudon, deputy director of finance at Cheshire and Merseyside Integrated Care System, said it felt like people had been left to their own devices in trying to balance sustainability with regulatory requirements.

'Where the challenge of meeting a regulatory requirement and hitting the financial performance measures is butting up against something that is not quite defined in regulatory terms at this stage, will accountability be qualified in so far as you have sacrificed some of your financial delivery for something that is very valued?' he asked.

'The agendas don't blend together. Part of that is due to the regulatory interface. I'm not using that as an excuse,' continued Mr Gloudon. 'It's a real issue that organisations




will face, so we probably need to look at the regulatory landscape again and reconsider how social value finds its way into there.'

Mr Hind suggested a change of emphasis in performance management. 'I think there's a massive role for finance, and finance can help the procurement teams in trusts. Do we need to move away from giving procurement teams a savings target every year? Maybe we could give them a reduction in carbon footprint target instead.'

Others thought procurement and finance should be focused on whole-life cost models, not price. 'It's absolutely essential that the financial criteria align to the outcomes you want to achieve over the lifetime of the contract, and the contracts are of a duration to achieve those outcomes,' said Mr Knott.

Ms Bailie reassured the roundtable that 'conversations with regulators are happening now about how we build sustainability into accreditation.'

Newcastle upon Tyne Hospitals NHS Foundation Trust associate director of sustainability James Dixon said measuring social value and sustainability was complex, and each procurement was different. Some tenders are carried out centrally, which the trust can't influence, but in locally procured contracts there is a greater opportunity to embed sustainability into the contract specification and evaluation criteria.

In a local procurement, the trust can focus on the detail of the specification, he said. 'How can we be clever and say we need, for example, circular economy principles, digital transformation, lower-carbon transport and logistics? If we get that in as requirements, all the bidders know what's needed, and you already have a lot of good sustainability content in there.'

The evaluation of bids is more difficult, he continued. 'Historically, it's been: "Do you have a certificated environmental management system? Do you have an environmental policy?" That isn't going to truly evaluate the sustainability offering from the supplier. It's not easy to do blanket statements for 5% or 10%, so we approach it on a case-by-case basis, putting more effort into contracts we know will have a big sustainability impact.'

## Electric bus service

One example he gave sparked much debate. The Newcastle trust tendered for two bus services, for patients and staff.

'We couldn't possibly get electric buses in that procurement if we'd gone for traditional procurement methods,' Mr Dixon said. 'So we went out and said this was our aim, and that we wanted their lowest price for the cleanest Euro 6 diesel, a hybrid and electric. The contract for the clean diesel was five years, the hybrid seven, and the electric buses 10.'

Doing the right thing doesn't necessarily mean higher cost, and the new bus service contract cost less than the previous contract.

Ms Bailie added that in national procurement of fleets, bus or delivery services, tenders have included social value weighting higher than 10%. 'Social value is not just about the metrics of emissions that we are now

HFMA ROUND TABLE

weighting and monitoring with those suppliers, but it's also around what they are doing locally, such as local employment, supporting that wider definition of social value, and how they are being efficient in their journey times.'

This is how the NHS will begin to shape the market, she added.

Alan Wain, former NHS Supply Chain chief operating officer, proposed that procurement teams should help finance colleagues by introducing a quantitative rather than qualitative assessment of the social value weighting. 'You can put a pound note sign against most of these items of social value or sustainability. You can even put a pound sign against the cost of carbon, because if you want to offset, there is a price for that.'

Financial values for sustainability measures make it easier to argue in favour of the environmental case, he insisted. 'You can say it's worth paying a bit more because this is the offset we get in sustainability value. But it comes down to CIP plans, and a recognition of that value or that saving you've made on the carbon footprint in the submissions going back to the centre. Unless the centre recognises it, and will offset a CIP plan pound note saving against a carbon saving, then you are going to be struggling against competing forces.'

Participants agreed there was room for improvement in NHS contract management, ensuring suppliers delivered on their sustainability promises. Some pointed out that free Cabinet Office training on contract management is currently available to the NHS.

'There is a risk this will be a "tick and forget" type exercise,' Mr Hind continued. 'It will be looked at during evaluation, and then never managed by the service user because the service user will be interested in whether they are getting what they need and not so much in whether they are getting the additional social value that was promised.'

He asked: 'Is there an appetite for finance colleagues to invest in more contract and supplier management, and challenge if they don't think it has been done?'

Enabling digitisation could help NHS bodies monitor progress, according to Lexmark's Sylvie Thomas. 'This is vital to getting transparency on the materials your supplier is using – is it not only recyclable, but also from sustainable sources? Indeed, Mr Knott proposed the use of digital platforms to increase understanding and improve monitoring, because a lot of the information on social value is now available in real time. The assembled experts agreed this was a 'real opportunity' for the NHS.

HFMA ROUND TABLE

Mr Knott also challenged the idea that social value and environmental sustainability always cost more. 'There are great case studies exposing where it can cost less because you are transforming a market or changing the specification fundamentally. And, measured on a whole-life cycle basis, you save money.'

Ged Murphy, East Cheshire NHS Trust executive director of finance, planning and estates and the corporate lead for the green agenda, has around 20 years' experience of implementing green measures across the NHS in the North West of England. He believes COP26 offers an opportunity to move the sustainability agenda ahead in the NHS.

He said the digital agenda is seen as an enabler to the focus on sustainability. The allocation of funding is due to change soon, moving to integrated care systems (ICSs), which will have a more local focus.

'We had the macro picture of funding and the pepper pot with the global digital exemplars, but I think there's a great chance at ICS level to build in bitesize chunks within a framework to get things moving.

'There's lots of random patterns out there, so the best are really good, while there are other trusts, like my own, still heavily reliant on paper records in a digital age. There are huge disparities, so with this new way of allocating resources there is the potential to get this moving and to get some cohesion.'

## ICS opportunity

Lee Outhwaite, finance director and executive director lead for net zero at Chesterfield Royal Hospital NHS Foundation Trust, saw the introduction of ICSs as an opportunity to embed sustainability in NHS services.

'The debate is about do we reduce the carbon associated with our as-is service delivery, or is the thing that will make the difference how we defragment and provide integrated care that will consume less carbon because it will be less episodic.'

The NHS must get on and implement integrated care as it will keep patients out of carbon-generating environments, such as hospitals, he added.

Ms Bailie said she was developing a sustainability forum with NHS suppliers. This aimed to support the implementation of the government pledge that, from 2030, the NHS will only contract with suppliers that meet its sustainability ambitions..

The NHS England team has been working to better understand the market, recognising suppliers that have sustainability targets in place, and those that are leaders in the field. This will begin to give the NHS visibility of these suppliers, but with tens of thousands of suppliers it will take time.

**"Digitisation is vital to getting transparency on the materials your supplier is using"**
**Sylvie Thomas**

Before the end of the year, social value guidance will be published, setting out the areas that could be measured. However, Ms Bailie stressed that NHS organisations should be discussing what they want in terms of social value. 'A lot of the priorities are local and not just about sustainability. It's about starting to quantify those, and put a value against them, to help business cases and the decisions we take in the NHS,' she said.

Lexmark's Sylvie Thomas called for 'global system thinking' on sustainability, with the NHS addressing not only recycling but other outcomes for the goods it uses. This could support the wider social value agenda. Trusts should consider durability, servicing, and managing demand.

Leasing products, combined with maintenance and other services, helps a shift towards more local added value, such as employment, she added. Circularity – manufacturing products to allow easier repair or remanufacturing – can boost local or regional employment. 'This can create positive loops. As you streamline this process, as you keep the product for longer, you also reduce costs. Recycling is good, but it is not enough.'

The NHS should support local SMEs, which stepped forward to help during the pandemic, Neil Hind said.

'We have examples of firms in Greater Manchester that stood up, invested, but then couldn't compete in the market, which is a massive shame.

'How do we take account of the cost of resilience and the social value these SMEs are bringing? Lots of work has been done in the North East about the local multiplier, known as "sticky money" – where a pound spent in a region gets spent time and time again. Are we missing an opportunity to keep more of our spending in the country?'

Finance managers have a clear central role to play in meeting aspirations on environmental sustainability and social value, and in driving the right conversations all the way to board level. There is much to be done and barriers to be overcome, but also much to gain.

# Thank you to all HFMA corporate partners for their continued support

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# IFRS 16: timeline sets milestones for new leasing standard introduction

Technical

It feels like it has been forever, but all of the signs are that the new accounting standard for leasing – IFRS 16 – will finally be implemented in the NHS from 1 April 2022, *writes Debbie Paterson.*

Following the two-year deferral to allow NHS bodies to deal with the small matter of a pandemic, there will be no more excuses.

The leasing standard has been part of business-as-usual in the private sector since 2019, including bodies such as NHS Property Services. And a handful of government departments have already adopted the standard, so the rest of the public sector has to catch up.

NHS England and NHS Improvement, along with the Department of Health and Social Care and the Treasury, have updated their guidance. Importantly, there is a new implementation timeline and there are several deadlines coming up.

The first thing that NHS bodies will have to do is complete a return to allow the Department to inform the Treasury of the expected impact of the new accounting standard on the capital and revenue departmental expenditure limits (CDEL and RDEL) in 2022/23.

This return will be made available to NHS bodies in early December for submission in January.

At the same time, the 2022/23 planning will be on an IFRS 16 basis. This means finance teams will need to have a good understanding of their operational plans for 2022/23, and whether those plans will involve new lease arrangements or renegotiating existing leases.

During the final quarter of the year, there will be another agreement of leases exercise. This was last run in 2019 and allows NHS bodies to agree, or not, whether there is a lease arrangement between them.

The exercise will focus on the arrangements and will not include any agreement of values or lease terms.


SHUTTERSTOCK

2022/23 planning will be on an IFRS 16 basis. This means finance teams will need a good understanding of their operational plans and lease arrangements

The Treasury has mandated the transition arrangements that public sector bodies will adopt when implementing IFRS 16.

It will allow for lease arrangements to be grandfathered from international accounting standard IAS 17 to IFRS 16 – leases under the old arrangements will remain leases under the new and vice versa.

However, this comes with a big caveat – that an assessment of whether a contract included a lease had already been undertaken in accordance with IAS 17 and its related interpretations, IFRIC 4 and SIC 27. If this assessment has not been undertaken, then it will need to be done as part of the transition.

Ideally it would be done ahead of completing the 2021/22 accounts, so that the transition can be made on the grandfathering basis.

If there are contracts that contain leases identified during 2021/22, then the classification error will have to be adjusted before the transitional transactions are accounted for.

There will be more disclosures required if the correction of errors takes place on 1 April 2022 rather than the day before.

IFRS 16 requires finance teams to make a lot

**continued overleaf**

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**continued from page 45**

of judgments and estimates – about whether it is a lease, what options will be taken up and the likely length of the lease.

All of these need to be made prior to transition and documented with reasons, as well as the evidence supporting the decisions that have been made.

This will be needed by auditors, but also by future finance teams over the life of the lease.

Finally, finance departments often keep changes to their professional accounting standards to themselves.

The rest of the organisation carries on in blissful ignorance of the work being done by the financial reporting team to meet a new standard's requirements.

This is not always the best approach to take. The audit of the 2020/21 accounts was difficult for many reasons, but one was that the adoption of IFRS 15 – the standard covering revenue from contracts with customers – had largely been treated as a year-end exercise rather than being embedded into systems.

This meant that evidence relating to payments from clinical commissioning groups that were not backed by contracts or formal arrangements were not considered from an IFRS 15 perspective, so income was difficult to evidence.

For the leases standard, it will be even more important that everyone negotiating or signing a contract understands that whether that contract contains a lease is a vital consideration.

Work should be ongoing educating the rest of the finance team, legal teams, procurement and estates.

And systems need to be embedded for managing and collecting lease information throughout the organisation.

***Debbie Paterson is the HFMA's policy and technical manager***

# Technical review

## A roundup of recent technical developments

Technical

System oversight framework **segmentation decisions** for all integrated care systems (ICSs) and trusts have been set out by NHS England and NHS Improvement. The national bodies have placed the local organisations into four segments, indicating the scale and general nature of support needs. Bodies in segment 1 have no specific needs, while those in segment 4 have been judged to require mandated intensive support. Five of the 42 ICSs have been placed in segment 4, while just one system – Frimley Health and Care – has been assessed as segment 1. The remainder are almost evenly split across segments 2 and 3. In the provider segmentation, released at the same time, 32 trusts and foundation trusts were in the top segment, having the least support needs. **hfma.to/dec211**

HM Revenue and Customs has confirmed that any potential reform on the **public sector VAT regime** will not be implemented within this Parliament – so not before 2024/25. In August 2020, the Treasury issued a consultation paper setting out options to simplify section 41 rules, under which public sector bodies claim refunds for VAT for goods and services. Its preferred option was 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. A response paper to the original consultation was issued in July. Further work and engagement is under way ahead of any decision being taken. The HMRC confirmation that potential changes remain some years away was given in an update to the HFMA VAT Sub-committee. **hfma.to/dec212**

A review of the governance of Scottish **NHS endowment funds** has found an 'inherent conflict of interest' in the structure of funds. This relates to the dual role of NHS board members, who are also officers of the corporate trustee of the related charity. The review, which was completed in 2019 but had publication delayed by Covid-19, made 28 recommendations to improve governance, including replacing the existing corporate trustee with a charitable board, which would comprise an independent chair and a majority of independent members. It also recommended publicly available governing documents for each fund and the introduction of limited liability for board members of the funds. In a statement to the Scottish Parliament, health and social care secretary Humza Yousaf said he accepted the review recommendations 'absolutely in principle'. But he said there was work to be done on precisely how they are taken forward. Fully adopting the recommendations would require legislative change. **hfma.to/dec213**

The **Exceptional Quarterly Collection project** closed at the end of October. NHS England and NHS Improvement set up the cost collection last year to help develop an understanding of the costs of delivering Covid care and the impact of the Covid pandemic on the unit costs of non-Covid care. The voluntary collection, completely separate from the National Cost Collection, involved the submission of aggregate level costs, for example with acute trusts submitting average costs for healthcare resource groups, and had a more limited scope. In a costing newsletter, the national bodies said the decision had been taken following extensive engagement with the trusts involved and the wider costing sector.

**Integrated care board (ICB) allocations** will include funding for most acute, ambulance, community and mental health services, according to new guidance. *Management of NHS resources by integrated care boards* said allocations will be based on the existing needs-based formula used for clinical commissioning group budgets, ensuring financial stability and equity. ICBs will have the power to set place-based budgets – they will not be set by NHS England and NHS Improvement. ICB running costs in 2022/23 will be the equivalent of an aggregate of CCG administration allowances for 2021/22. Providers will map to a single ICB – at least initially – with 'significant providers' of services to an ICB expected to be formal partners of the ICB. The partnership will mean that providers will have to agree to the system five-year plan and annual capital plan. They will also be able to receive ICB grants and participate in its governance. The guidance was published on the Future NHS platform.

# MBA programme to have first intake in new year

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

Training

From January, learners completing an HFMA advanced higher diploma in healthcare business and finance will have a new route to accessing an MBA, *writes Steve Brown.*

Since 2019, the HFMA has offered access to an MBA through a programme developed by BPP University. However, from next year, successful students will be able to join an executive MBA top-up programme at the University of Northampton, leading to an internationally recognised degree.

An MBA degree equates to 180 educational CATS points. Completion of the HFMA advanced higher diploma would provide a student with 120 points and the opportunity to take part in the executive MBA top-up programme (worth the further 60 points).

The Northampton executive MBA top-up has elements designed specifically for HFMA entrants, with a 10-credit module exploring critical issues in healthcare finance.

'This will involve them researching one aspect of NHS finance that is affecting them and they research it in an academic way,' explained Ewan Tracey, a senior lecturer in accounting and finance at the university.

However, for the second module, worth 50 credits and the bulk of the programme, HFMA diploma graduates will join a wider cohort of MBA students to undertake individual business research projects. 'This will include people from across the world and different industries,' added Mr Tracey.

Each student will tackle a project of their own choice – normally drawing on a live issue from their own organisation. But they will learn the frameworks for those projects together.

Mr Tracey said the executive MBA – which is based on distance learning to suit busy professionals – has been successful over a number of years. It attracts about 100 students each year, alongside 500 on the university's wider MBA programme.

While the programme is run by the university's business and law faculty, there are also connections with Northampton's health and social care faculty.

To date, 18 graduates from the HFMA's diploma programme have advanced to the MBA programme run by BPP. However, there is a lot of interest among current students about moving up to the MBA programme. 'We had 30 interested candidates attending a webinar about the new Northampton programme recently,' said Emily Osgood (pictured), head of education and professional development at the HFMA. 'And with more people graduating the diploma programmes, we are anticipating increasing numbers moving on to the MBA.'

MBA students will continue to be supported by the HFMA's Policy and Research Committee, which will discuss research proposals with students and assign a non-academic sponsor to each student – an approach that was introduced in 2019 and has proved successful.

Earlier this year, the HFMA published a summary of a recent research project from a recent MBA graduate. The project was undertaken by Edward Gold, head of costing and income at East Suffolk and North Essex NHS Foundation Trust, and explored how patient-level costing could be used as a tool to add technical value within healthcare systems.

Some 650 people have so far embarked on either a module or diploma as part of the HFMA healthcare business and finance qualifications or its *Diploma in advanced primary care management*. Nearly 300 have completed diplomas across the two programmes, with another 160 currently enrolled.

A further 55 will graduate the diploma programmes in December, with many of them receiving their certificates at a presentation during the HFMA annual conference.

## EDI action plan launched

One NHS Finance

A national equality, diversity and inclusion (EDI) action plan for NHS finance was launched in November at the One NHS Finance inclusion conference.

The plan has been developed by the Finance Leadership Council, members of the One NHS Finance top team, and volunteers from across the finance community.

The plan outlines six national objectives underpinned by actions with ambitious, measurable indicators. These aim to empower everyone working across all grades and NHS organisations to contribute towards making NHS finance a great place to work, supporting world-class healthcare.

'This action plan provides ways to improve the "what" – which looks at improving diversity and our current representation – along with the "how", where inclusivity and equity of access are crucial to making our working environments a place where everyone belongs,' said Hardev Virdee (pictured), chair of the National Finance Academy and group chief financial officer at Barts Health NHS Foundation Trust.

The six objectives – leadership; representation; recruitment; awareness; support; and data and information – build on the work being delivered across the regions.

Also outlined are the expectations at all levels – specifically aimed at the Finance Leadership Council, finance directors and senior leaders, the regional finance academies, systems and organisations, line managers, and individuals.

Networks such as the inclusion and diversity ambassadors, value makers, and sponsorship programme participants are highlighted throughout the plan.

This empowers them to continue championing this agenda and to provide feedback from staff 'on the ground' at all levels to the senior teams leading this plan.

**• Download the EDI action plan from the ONF website hfma.to/l1z**

# Diary

**Most events continue to be delivered online**

## January

12 B Eastern: introduction to NHS finance
18 H Chief finance officer and director forum, London
20 B South West: lunch and learn – how to build our confidence in speaking both online and offline
20 B South West, South Central and West Midlands: developing talent student conference
20 I Introduction to NHS costing
21 W ICS stories: the importance of relationships in Hampshire and the Isle of Wight
25 B South West: lunch and learn – self-awareness and self-management, the key to emotional intelligence
26 B London: VAT level 1
26-27 N Pre-accounts planning
27 B South West: lunch and learn – how to make virtual conversations more real

## February

08 H Annual chairs' conference
10 H Finance managers' forum
16 H Integrated care summit
17 I Costing together, London
17 B South West: lunch and learn – a new approach to time management that's honest and healthy
23 B South West: lunch and learn – understanding others and managing relationships
24 B South West: lunch and learn – the way we think and how to make the conversation with our inner voice a supportive one
22-23 B Eastern: annual conference, hybrid

## March

08 H NHS leadership and chief executive network forum, London
10 I Value masterclass
16 H Audit conference, London
16 B Eastern: lunch and learn – introducing the NHS social value assessment tool

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

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

## Branch contacts

**Eastern** kate.tolworthy@hfma.org.uk
**East Midlands** charlotte.bradbury2@nhs.net
**Kent, Surrey and Sussex** elizabeth.taylor29@nhs.net
**London** tori.crutchley@hfma.org.uk
**Northern Ireland** kim.ferguson@northerntrust.hscni.net
**Northern** catherine.grant2@nhs.net
**North West** gayle.wells@merseycare.nhs.uk
**Scotland** alice.johnson-jelf@hfma.org.uk
**South West** charlie.dolan@hfma.org.uk
**South Central** tori.crutchley@hfma.org.uk
**Wales** charlie.dolan@hfma.org.uk
**West Midlands** alice.johnson-jelf@hfma.org.uk
**Yorkshire and Humber** laura.hill36@nhs.net

## Events in focus

### CFO and director forum
**18 January, London**

This high-level briefing aims to provide senior leaders with an opportunity to begin the new year by reflecting on the past months and refocusing on the challenges ahead. The event will be held under Chatham House rules, so presentation slides will be available afterwards with speaker permission, but session videos will not be shared.

Confirmed speakers include Suzanne Tracey (pictured), chief executive of Royal Devon and Exeter NHS Foundation Trust, and Wes Baker, director of strategic analytics, economics, and population health management at Mersey Care NHS Foundation Trust. The newly crowned HFMA Finance Director of the Year for 2021 will also be invited to make a presentation.

Topics to be covered include NHS efficiency, health inequalities, the drive to NHS net zero, and approaches to population health management.

HFMA Hub partners are entitled to one free place for this event, though additional tickets can be purchased. Tickets are also available to non-members for a fee. You can check if your organisation is a Hub partner or get further details on becoming a partner on the HFMA website.

- **Email laurence.sampson@hfma.org.uk for details**

### Integrated care summit
**16 February, online**

This event offers the opportunity for those working in primary and secondary care, integrated health systems, and local government to virtually discuss their common priorities, challenges, and best practice. A wide range of topics will be covered, including national progress on integration, capital allocations, and joint working partnerships between health bodies and local authorities. Discussions will also focus on ironing out remaining details in the establishment of integrated care boards, as well as supporting primary care to improve service provision and population wellbeing. The event will be chaired by Kathy Roe (pictured), director of finance at Tameside Metropolitan Borough Council and Tameside and Glossop Clinical Commissioning Group. Confirmed speakers include Susannah Howard, ICS programme director at Suffolk and North East Essex Integrated Care System.

HFMA Hub partners are entitled to one free place, and non-members can purchase tickets.

- **Email laurence.sampson@hfma.org.uk for details**

**NEW COLOURS**
You may have noticed things are looking a little different this issue. Welcome to our new look. Our new colours have been chosen to align with our aim to be an accessible and digital organisation. It also underlines our enthusiasm to promote environmental sustainability best practice. Expect to see future outputs – from the national association and its branches – to sport the new look.

# In development

**Association view from Mark Knight, HFMA chief executive**
To contact the chief executive, email chiefexec@hfma.org.uk

My HFMA

The HFMA annual conference is upon us again and I cannot believe it's been two years since we've all been together. Even now, yet another variant, omicron, is with us and, understandably, the concern level has increased.

The morale of the NHS is being severely tested as we work through a very grim winter. As usual, the finance profession is doing its outstanding best to support clinical colleagues, with the association providing timely advice and help.

The service is not standing still and focusing solely on Covid-19. We are moving rapidly towards a reconfiguration, with a greater focus on systems. There remain significant financial challenges – both in terms of revenue and capital. And as for technical changes, we will finally see the application of the new accounting standard for leasing in April (*see page 45*).

One aspect of the support provided by the HFMA is the opportunity for training and development. Our HFMA Hub provides a tailored programme through our growing number of networks. We hope in 2022 to continue our themed programmes, many online, some hybrid and a few face-to-face only.

This is supplemented by our network of professional committees. A good example is the Accounting and Standards Committee, which focuses on the detail of financial accounting. That committed group helps out at the ever-popular pre-accounts planning conferences.

Our branch network provides a further support mechanism. I wasn't able to get to the Northern Branch, but I did make the Yorkshire and Humber, Kent, Surrey and Sussex, and East Midlands annual conferences – all excellent events, well attended and organised with aplomb by the local leaders and committees. I hope that by the summer, we'll be a in better position to host more face-to-face events.

But there's much more to our development opportunities. There are about 180 hours of free e-learning on the electronic staff record (for England and Wales staff). This bite-sized content is supported by a grant from NHS England and NHS Improvement and arranged into 28 topic areas. If you're in the NHS, it's free to access, and 30,000 courses have been assigned to learners. Why not join in?


HFMA chief executive Mark Knight

And so to the conference. This is a chance to listen to first-rate speakers and for face-to-face delegates to meet again. It will be a great event that we hope will start to draw a line under the past two years. We have some amazing speakers across the five days and it will be an opportunity to meet new president Owen Harkin.

I couldn't finish the year without thanking one individual who has led us for two years. Caroline Clarke doubled her time as president, despite her incredibly busy role as group chief executive of the Royal Free London NHS Foundation Trust.

Caroline is an amazing person, who leads and inspires not only at the HFMA, but also at her own organisation. I've known her since 2003, but the past two years I've had the privilege of seeing her operate at close quarters. Thank you, Caroline, for all your amazing work. You will always have a special place at HFMA.

I'm sure she would say she was once an aspiring junior too. And if you want to get involved with us, I guarantee you'll get as least as much out as you put in!

## Member news

The **Northern Branch** football team (pictured right) reached the quarter final of the 2021 Newcastle Charity Football Tournament. The event raised more than £1,500 for If U Care Share, which aims to prevent suicide and support communities.

**Kent, Surrey and Sussex Branch** has held its awards:
- Student of the Year: David Wilder
- Finance Team of the Year: Dartford and Gravesham NHST
- Outstanding Contribution: Reg Middleton
- Overcoming Adversity


Award: Surrey and Borders Partnership NHSFT.

**West Midlands Branch** also presented its annual awards:
- Finance Team of the Year: Midlands and Lancashire CSU
- Resilience Award: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHSFT

**Kent, Surrey and Sussex** raised £3,300 at its branch conference for the charity Grassroots Suicide Prevention.

At its conference, the **Scotland Branch** organised a Strava event at which delegates ran, walked, swam or cycled 5k, using the app to record their progress and upload photos. Prizes went to the furthest distance (Ros Philip); best Halloween selfie (Casey Miller and daughter); and most scenic route (Lorraine Grant).

A cricket team including **North West Branch** vice chair Gayle Wells raised £425 in aid of the Ruth Strauss Foundation, in memory of the wife of England cricketer Andrew Strauss. The team, the Maghull Maidens, will travel to Lords Cricket Ground next spring to take part in a coaching session by Sir Andrew.

# Appointments

**Vicky Clarke** (pictured) has been named as the Royal Free London Group's new chief finance officer, moving on from her current role as deputy chief finance officer at University College London Hospitals NHS Foundation Trust on 13 January. She has worked across the NHS in various finance roles, including the Royal Free seven years ago. **Tim Callaghan** is currently interim group chief finance officer at the Royal Free, having joined the trust as director of financial performance (Royal Free Hospital) and deputy group chief finance officer in 2019. Prior to joining the trust, he held a range of senior finance roles, including at Royal Brompton and Harefield Hospitals, which is now part of Guy's and St Thomas' NHS Foundation Trust.

**Neil Guckian** (pictured) has been appointed chief executive of Western Health and Social Care Trust in Northern Ireland. He joined the trust in 2019 as director of finance and contracting and succeeds **Anne Kilgallen** as chief executive. He has worked in the health sector for more than 20 years, holding board-level finance and deputy chief executive posts. He is a staunch supporter of the HFMA, speaking at many events and serving as chair and deputy chair of the Northern Ireland Branch. He was made an HFMA honorary fellow in 2014. **Paul Quigley** is acting director of finance, ICT and contracting.

**Eva Horgan** (pictured) is now chief finance officer at Liverpool Women's NHS Foundation Trust. She joined the trust in 2018 as deputy director of finance, winning the HFMA Deputy Finance Director of the Year Award in 2019. Ms Horgan started her career on the NHS graduate training scheme in 2004 and has worked in senior finance roles at NHS organisations across the community, mental health, acute and commissioning sectors. She succeeds **Jenny Hannon**, who is now chief finance officer at Lancashire and South Cumbria NHS FT.

**Catherine Teggart** has been named director of finance, procurement and estates at the Southern Health and Social Care Trust in Northern Ireland. She has extensive public sector finance experience, having worked in the Department of Justice and the Probation Board for Northern Ireland over the past 18 years. Ms Teggart succeeds **Helen O'Neill**, who has retired.

Sherwood Forest Hospitals NHS Foundation Trust has appointed **Paul Robinson** (pictured) interim chief executive. Mr Robinson's substantive role is the trust's chief financial officer and deputy chief executive. A chartered management accountant, he joined the trust in 2015 and became deputy chief executive in 2019. He has been in the NHS for more than 30 years. While he is acting chief executive, **Richard Mills** will be interim chief financial officer. He has more than 15 years of NHS finance experience, having joined the NHS graduate management training scheme in 2006. The first 18 months of his career were spent with Sherwood Forest's finance team, and, after holding finance posts around the Midlands, he re-joined the trust in 2019 as deputy chief financial officer.

## Sewell-Jones in Herts move

**Adam Sewell-Jones (pictured), chief executive of Newham Hospital and group director at Barts Health NHS Trust, has been appointed chief executive at East and North Hertfordshire NHS Trust.**

**He succeeds Nick Carver, who is retiring at the end of the month.**

**Mr Sewell-Jones has a wealth of NHS experience at trust and national level. A qualified accountant, he has held a number of senior NHS finance roles at trusts in London and the South East, and general management posts, including as deputy chief executive at Basildon and Thurrock University Hospital NHS Foundation Trust.**

**At a national level, he was executive director of improvement at NHS Improvement.**

**He commented: 'I am thrilled to have been offered the role as chief executive of East and North Hertfordshire NHS Trust, and am looking forward to working with our staff, service users and partners to deliver high-quality care to our communities.'**

**Ellen Schroder, the Hertfordshire trust chair, said: 'I look forward to working with Adam as we recover from the impacts of the pandemic. Our priorities will continue to be to deliver high-quality care while developing and supporting our people to be the best that they can be.'**

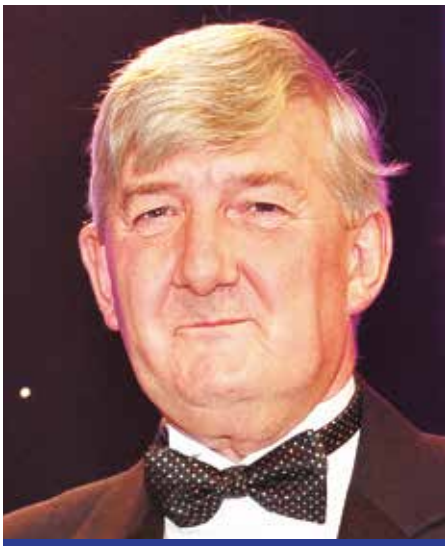
**Jonathan Wood**, Lancashire Teaching Hospitals NHS Foundation Trust's deputy chief executive and director of finance, has also been appointed chair of the NHS Supply Chain North Customer Board for Procurement and Supply. In addition, he will join the national customer board, which aims to influence and lead procurement strategy.

**Rod Smith** (pictured) has retired from his role as project director at East Sussex Healthcare NHS Trust. A former chief finance officer, he founded the HFMA Environmental Sustainability Special Interest Group and was awarded an HFMA honorary fellowship in 2020. Originally due to retire last year, he extended his employment to ensure projects he was working on hit key milestones – in the process completing 35 years in the NHS. He is now hoping to build on his work with the environmental sustainability group, and is open to taking voluntary roles.

**Chris Sands** has moved to Midlands Partnership NHS Foundation Trust as chief financial officer after 10 years at Derbyshire Community Healthcare NHS Foundation Trust. He was chief financial and strategy officer, and deputy chief executive at the community trust. Chesterfield Royal Hospital NHS Foundation Trust director of finance and contracting **Lee Outhwaite** has become Derbyshire Community's finance director in a joint role, retaining his existing portfolio at Chesterfield.

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

"Other people have had to move between organisations to progress, but I've worked in an organisation that's always developing, allowing me to move around within the same organisation"
**Martin Shaw**



Martin Shaw at the 2014 HFMA Awards

# Health service stalwart Martin Shaw to retire

**On the move**

Martin Shaw has spent the past 40 years in the NHS, becoming synonymous with Guy's and St Thomas', and helping grow its annual turnover from £400m to around £2.4bn.

The Guy's and St Thomas' NHS Foundation Trust chief financial officer retires at the end of this month, having joined the NHS in 1981. After studying for his degree at Nottingham University, he joined a firm of chartered accountants, but realised it was not for him.

'Having undertaken my part 1 accountancy studies, I decided I didn't want to be an auditor,' he says. 'I went back into the graduate milk round and secured a place on the NHS graduate general management training scheme. I had only encountered a hospital twice in my 21 years, so I thought it best to get a summer job to see if I liked the environment before I went into the graduate scheme and committed to the NHS.'

Mr Shaw took up a summer post in finance at the Middlesex Hospital in central London and, by the end of the summer, found he had been promoted. At that point, he started supporting a Warwick University PhD student's research project, which involved building costing and planning models.

He worked in the Middlesex Hospital's finance team, which merged with University College London Hospitals, gaining his general management training qualifications, until he joined West Lambeth Health Authority in 1983.

He held a variety of posts at St Thomas' and, having returned to acquiring his professional accounting qualifications, held the post of deputy director of finance until 1993 when Guy's and St Thomas' merged.

Mr Shaw has remained at the trust and successor bodies ever since, initially as business and financial planning manager, then strategy director and projects director. He was appointed finance director in 1998 and became chief financial officer in 2017.

'I've done nearly every non-clinical job at the trust – I've been director of strategy, IT, estates and HR, as well as being in charge of finance. I've been lucky. Other people have had to move around between organisations to progress, but I've worked in an organisation that's always developing, allowing me to move around within the same organisation. I hope I have added value along the way.'

He has served as CFO in the last four years – a more strategic role away from the day-to-day finances. 'In this role I've been coping with the pandemic, as well as successfully merging with the Royal Brompton and Harefield Foundation Trust, and developing long-range financial planning models, business cases and funding packages to enable the hospital's longer-term capital developments,' he says.

Indeed, capital development, including the opening of the trust's Evelina London Children's Hospital and the Guy's Cancer Centre, feature prominently in his career highlights.

"Having clinicians involved in taking the decisions has helped, particularly in challenging financial times"

Does experience play a key role in completing these projects? 'Over the past 10 years, we have been able to develop our estate because we have been successful financially. No doubt the more experience you get, you realise a project's success is based on good relationships.'

Expanding on this theme, Mr Shaw says any development in the NHS must include clinicians as early as possible.

'The reason we have been as successful as an organisation is the clinical involvement in its operation and management. We have experienced good and bad times financially over the years, but having clinicians involved in taking the decisions has helped, particularly in challenging financial times.

'Our clinicians treat finances as any other quality standard, as you can guarantee they have ideas to improve things for patients, which also help you achieve value for money.'

Mr Shaw has been a supporter of the HFMA throughout his NHS career, and chaired the association's Foundation Trust Finance Faculty for eight years. He was made an honorary fellow of the HFMA in 2014 for his contribution to the association's work.

'The HFMA has been great over the years, and it has an ability to pull in speakers from finance and from the top of the NHS. It has helped people in their careers as it's a good way to network, and it gives people a support network when times are tough. It adds real value.'

Looking back, he says it is important to be surrounded by 'good caring people, to enjoy your job and to have support from your colleagues, family and friends.'

So, what does he plan to do next? 'I have three children in their 20s, with one getting married in July with the reception at home. I am sure there will be lots to occupy me to get ready for that.'

Guy's and St Thomas' is like a family, he continues, and will be difficult to leave completely. 'I will still be supporting Guy's and St Thomas' in the background. I've had offers from elsewhere, but at the moment I'm not committing to anything. I want to have a break while I decide and then see what I want to do next.'

Trust chief executive Ian Abbs paid tribute to Mr Shaw 'for his extraordinary financial leadership over many years'. He adds: 'This has delivered the financial stability for which the trust is rightly known and has allowed us to pursue key strategic ambitions for the benefit of our patients.'

Mr Shaw will be succeeded by Steven Davies, the trust's current finance director. Mr Davies has more than 20 years' NHS experience. Before joining Guy's and St Thomas' in 2018, he served as chief financial officer and deputy chief executive at Moorfields Eye Hospital NHS Foundation Trust.

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