healthcare finance

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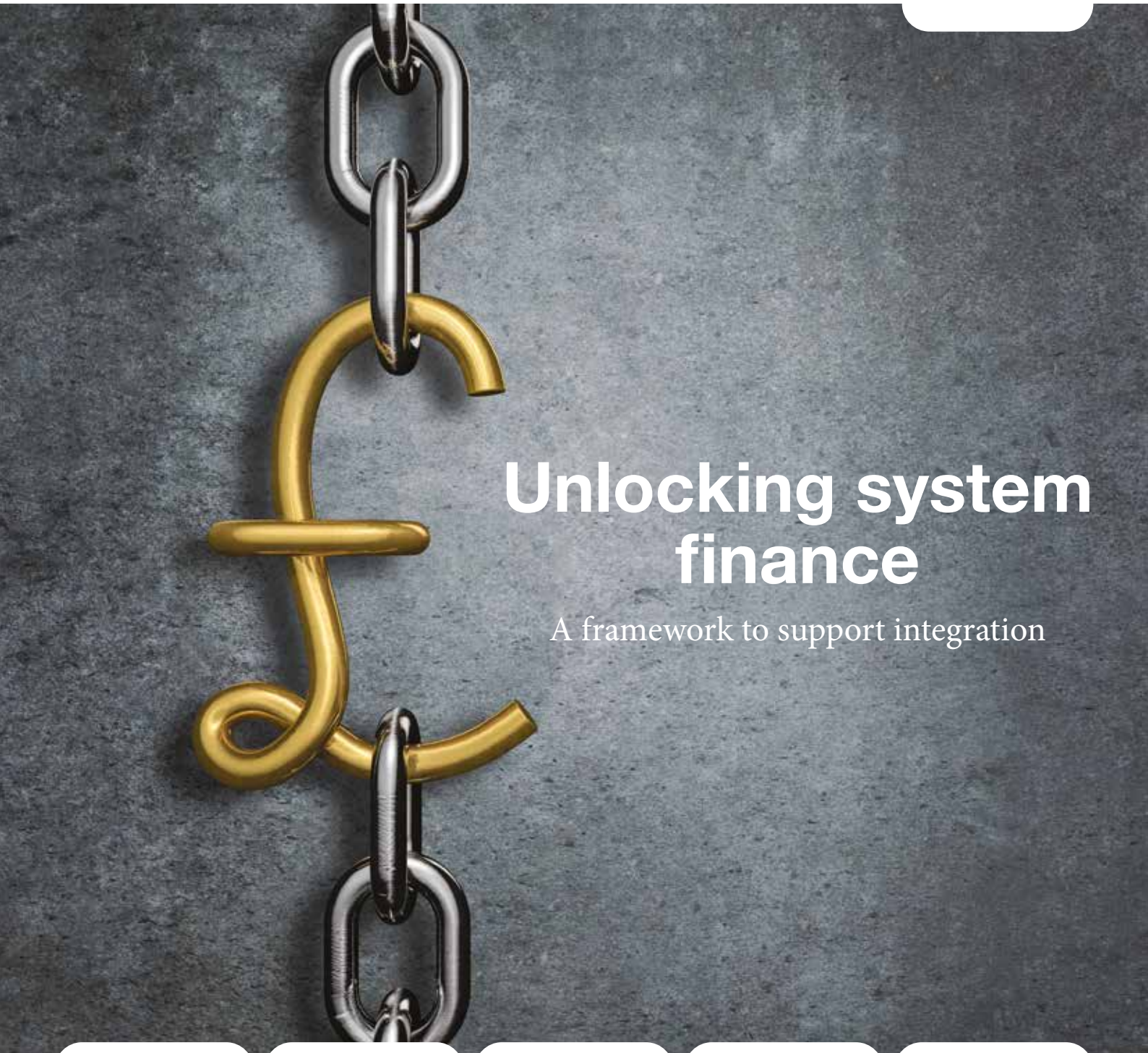

Unlocking system finance

A framework to support integration

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In conversation with: Hardev Virdee

Hardev Virdee
Group Chief Finance Officer for Barts Health NHS Trust

Many finance professionals working in the public sector are driven by their desire to tackle inequality, improve people's life chances, and make a difference to communities. Here, Hardev Virdee speaks to CIPFA CEO Rob Whiteman about how his values and background have driven his career in public service

Hardev's career in the NHS began more than 20 years ago, when he joined the organisation's graduate finance training scheme in 1996. It was as a graduate trainee that Hardev first began his CIPFA training, gaining his qualification in 2000. He gained his first board role as Finance Director at Hounslow Primary Care Trust (PCT) in 2009, building up a portfolio of board roles across various NHS organisations before becoming Group Chief Finance Officer for Barts Health NHS Trust.

Rob: Nice to chat to you again Hardev. So what was it about the public sector that first piqued your interest?

Hardev: Following my economics degree, it was clear I wanted to work in finance. After university, I applied for various graduate programmes in both the public and private sector. I was offered a place on the NHS training scheme as well as a lucrative training package from the bank I was working for at the time. I had to think really carefully about my values, what I really wanted to get out of my career, and what I wanted to achieve in the long term.

R: And that led you to a career in the NHS?

H: Yes - public service and making a difference were really important for me. What really swung it was my upbringing. I grew up in a very deprived area where you could really witness the impact in differences in health and social economics, and the levels of inequality that existed. I wanted to make a difference to the health inequalities that people faced, particularly where I grew up. That social conscience aspect played a big part in my decision. Throughout my career, I've found that many people working in the public sector have the same values – wanting to make a difference and improve the quality of life for others.

R: I couldn't agree more. That public service ethos really is at the heart of what we do. What would you say have been your career highlights?

My CIPFA qualification was the first highlight! Another significant moment was gaining my first board role as a finance director at Hounslow PCT in 2009, at what was then a relatively young age. The first week in that role also coincided with me becoming a dad for the first time and buying a house, so that was a very memorable (and hectic) time for me!

Another highlight happened last year, when I was nominated as NHS Finance Director of the Year. To get that recognition from colleagues and peers was really important for me.

R: What have been some of the highlights in your most recent role?

Joining Barts Health NHS Trust was a big moment for me – being part of one of the largest healthcare organisations in the UK and Europe. Leading the finance function is a big challenge, and no sooner had I joined, we were facing a massive challenge with the COVID-19 pandemic. But being part of this organisation is also one of the most rewarding things I've ever done – seeing how the NHS has met its challenges over the last year has been an enormous privilege.

R: What's the best piece of advice you've given? And what advice would you give to people just starting out?

The most helpful advice I've been given is "Know your weakness and surround yourself with good people." It was from one of my finance directors when I was a trainee who gave me quite a lot of support. The other piece of advice he gave was "Really know what you stand for and your values." I like to think I've followed that advice throughout my career.

I really think bring your whole self to work is vital. Know and value what you bring to the table. Don't mould yourself on others; learn from them and really keep challenging yourself to make a difference.

You have to be really authentic to your values. That's got to come through, so really work hard on understanding how you can translate that into your leadership style.

R: How has being a CIPFA member supported and influenced you?

I play an active role within CIPFA and have seen the support it provides to its members. I've found the ethics work done by CIPFA to be particularly helpful and supportive in dealing with more complex issues.

It's an organisation where you can source information, find real thought leadership and share knowledge with others within the public sector. It's a great place, too, for people to find training and development, from student learning through to professional development.

News

NHS calls for more details on system oversight plan

By Seamus Ward

Details of a new, integrated system oversight framework are due to be published this month, but NHS organisations have called for greater clarity on how the framework will operate and details on measurement of system performance.

A consultation, which closed last month, said the new oversight framework will assess integrated care systems (ICSs), trusts and clinical commissioning groups against five themes, including: finance and use of resources; quality of care, access and outcomes; preventing ill health and reducing inequalities; people; and leadership and capability.

A sixth theme for 2021/22 will focus on local strategic priorities, recognising the unique circumstances faced by each ICS, and the 'renewed ambition' to support greater collaboration, accelerate progress in overcoming the most critical challenges, and support broader social and economic development.

"We need more details on what support will be provided from the SID and NHS England and NHS Improvement team"
Emma Knowles, HFMA (above)

ICSs, trusts and CCGs will be allocated to one of four segments. Bodies in segment 1 will earn the right to have the lightest level of oversight, including the ability to request devolution of programme funding, removing the requirement to account for resource deployment in exchange for agreed outcomes. They will have greater control over the deployment of improvement resources made available through regional improvement hubs.

Trusts and CCGs in segment 1 will also:

- Be able to request access to funding to provide peer support to other organisations
- Be exempt from the consultancy controls or relevant running cost limits
- Benefit from streamlined business case approval.

Segmentation will be phased in during 2021/22 and reflect the approach to operational and financial planning set out in the planning guidance. Segmentation decisions will be based on the assessed support needed and, by default, organisations will be allocated to segment 2.

NHS organisations in need of significant support will be placed in segments 3 or 4 and be subject to enhanced oversight by the national regulators, and could face additional reporting requirements and financial controls.

Bodies will be considered for mandated support and moved to segment 3 if, for example, they are reporting a negative variance against an agreed financial plan or are forecasting they will not meet their plan at year-end. Those in segment 4 will have long-standing, complex needs and previously been in special measures.

The current system of special measures, including financial special measures, will be replaced by an integrated recovery support programme (RSP), which will apply to systems, trusts and clinical commissioning groups in segment 4.

An integrated approach was needed to fit the new landscape, the consultation said. The RSP will differ from the special measures programmes in several ways.

The RSP will focus on systems while also providing support to individual organisations. It will be led by an experienced system improvement director (SID), who will co-ordinate an expert multidisciplinary support team.

Assistance could include: financial recovery support (for example, specialist help to reduce agency use or implement cost controls); a governance or drivers of deficit review; or intensive support for emergency/elective care.

Legally, NHS England must assess CCG performance annually. Currently, this is via the NHS oversight framework, which examines leadership, financial management, and performance in priority areas. For 2020/21, the assessment will be simplified as a result of Covid-19. A narrative assessment, based on performance, leadership and finance, will replace the ratings system previously used for CCGs.

The consultation proposed the 2020/21 approach be adapted for 2021/22 to ensure

greater flexibility, basing the annual performance assessment against the oversight metrics; specific key lines of enquiry, including breaking even and contributing to the reduction of system-level deficits; and an evaluation of how well the CCG works with others to improve quality and outcomes for patients. This will inform an end-of-year meeting with their regional team.

While welcoming a more system-focused support programme, the HFMA consultation response warned that it could lead to a greater need for resources in bodies that have not in the past needed support, but are located in a system that does need intervention. HFMA policy and communications director Emma Knowles said clarification was needed on a number of points.

'For example, we need more details on what support will be provided from the SID and NHS England and NHS Improvement team. Will this be asking for information, providing challenge, providing more money, or providing advice on how to use data to make improvements? As a joint appointment: who will pay for the SID; who will employ the SID; how does the SID fit with the organisational board and the ICS board?'

In its response, NHS Providers warned that using quartiles as part of the allocation into segments could be arbitrary and 'potentially unhelpful as it is relative to other trusts. This may lead to scenarios where, for example, a trust sitting just outside of the upper quartile is penalised for an effectively arbitrary banding. It would be useful to understand further how these criteria will be weighted against the additional judgements made to identify the correct segmentation for a trust.'

The provider body welcomed the commitment to use discretion and flexibility where possible in identifying the correct segment, particularly as finance metrics could affect many trusts – only half of trusts met their control total in 2019/20, for example, and could be pulled into segment 3 without a nuanced assessment of their performance and support needs.

Systems set for platform move as ISFE contract extended

By Steve Brown

In April, NHS England officially confirmed that it was extending the current contract with NHS Shared Business Services (NHS SBS) for the delivery of the Integrated Single Financial Environment (ISFE).

The extension provides stability in the transition to integrated care systems, and also buys time to consider the potential of a future solution covering human resources as well as finance. However, while the three-year contract extension – until March 2024 – implies a continuation of the status quo, in fact there is a busy time ahead for the shared services provider.

The ISFE was introduced in 2013 to provide a common accounting platform for NHS England and the newly established clinical commissioning groups. The platform – based on Oracle technology – uses a common chart of accounts and means all CCGs account and report in a consistent way. It also streamlines accounts consolidation for NHS England.

Wrapped around the core technology is a range of finance and accounting services. These include processing the 3.3 million invoices submitted each year for CCG payment and overseeing the approval process, collecting debt and the reconciliations and VAT returns.

The contract has been extended once before, in 2018, with the renewal due this year. However, the Covid-19 pandemic has pulled NHS England's focus to more immediate pressures.

Changing the contract just a year ahead of the demise of clinical commissioning groups and the introduction of statutory integrated care systems could also be regarded as an unnecessary disruption.

There will be no further extension beyond 2024, with a tender for the replacement ISFE system due to go live in July this year.

Stephen Sutcliffe, director of finance and accounting at NHS SBS, points out that the ISFE is one of the 'major systems in government'.

According to the contract extension notice, the extension will cost NHS England just short of £20m a year over the coming three years, and has already cost more than £126m over the eight years to date. 'Moving to a new provider is a big job involving systems, people and processes,' Mr Sutcliffe said. 'NHS England needed to give themselves enough time to go through a procurement process – and a year is probably what you'd expect given the scale of the project – and then the change programme.'

Over the more than 10 years of the contract, NHS SBS says it will have delivered savings of more than £40m in transactional costs alone, with non-financial benefits on top. For example, the delivery of consolidated reporting saves time and ensures stronger control and assurance.

The move to systems means some major changes for the ISFE as 106 CCGs disappear to be replaced by 42 ICSs.

In some ways, NHS SBS is familiar with the process. It has overseen the gradual merger of CCGs from the original 211 down to the current 106 – with 38 CCGs merging into nine new organisations in April this year.

'We've had a lot of success with merging CCGs' books in recent years and putting them onto one ledger,' says Mr Sutcliffe.

'We do that really well, but that doesn't mean it is easy. It is basically a six-month project to change suppliers, processes and people. So, while in some ways moving from the 106 CCGs to the 42 statutory ICS bodies is just a bigger project – it in fact involves changing all our ISFE customers.

'What we don't know yet is what the ICS statutory bodies will actually look like. There is some talk of them having wider responsibilities than CCGs – for example primary care and specialised commissioning responsibilities. So, it could also involve changing scope – and that is one of the added dimensions.'

"What we don't know yet is what the ICS statutory bodies will actually look like"
Stephen Sutcliffe (below)

In addition, a number of fledgling ICSs have been talking more broadly with NHS SBS about working as ICSs, the implications for existing finance systems and the impact on financial reporting (*see Technical, page 29*).

The technology is also changing. Mr Sutcliffe says the ISFE is already cloud-based – NHS customers were quickly able to access their ledgers and reports after last year's move en masse to home working as a result of Covid-19.

'But last year we moved all our Oracle system away from on premise – where our data centre was with Capita – and we moved it all to Oracle cloud infrastructure.

'So, our current version of Oracle – 12.2 – is in Oracle cloud. And we have a roadmap to move to the next version of Oracle – Oracle Fusion Cloud Financials – and this year we will implement the first stage of that move.'

This is based on more modern technology with a higher level of automation built in, doing away with the need for bolt-on robotic processes, and offers an improved user interface and enhanced reporting and analytics.

A model office will be set up this year to show to clients ahead of NHS SBS deciding on its implementation strategy.

There is one final issue in the mix. At the end of last year, NHS England launched a discovery project to assess the viability of a single system bringing together NHS finance systems with the electronic staff record. The enterprise resource planning (ERP) system could potentially provide finance, budgeting, procurement, recruitment, payroll, learning and talent management all within a single system. The age of the ESR and the re-tendering of the ISFE has presented an opportunity for an integrated approach.

While there are clear benefits from an integrated approach, there are some concerns that the sheer size and complexity of the project could create huge risks. And there may be other ways to realise the benefits.

Mr Sutcliffe says NHS SBS would be interested in bidding if that was the option the Department of Health and Social Care decided to pursue. But he said the services wrapped around any system would be as important as the system itself. And even if the single system did not go ahead, there was a clear requirement for systems to talk to each other better than they do today.

The ISFE contract extension may provide stability for NHS finance and accounting in the move to ICSs. But beneath the surface, there are significant changes taking place.

GPs call for more funding to underpin system success

By Seamus Ward

Primary care leaders have called for greater involvement in integrated care system (ICS) decision-making and have raised questions on the future funding of GP services under the new system model.

A survey and report by the NHS Confederation and Primary Care Federation Network said that only 12% of primary care leaders were always involved in ICS discussions.

The survey, of more than 200 primary care network (PCN) and GP federation leaders, said they needed more funding to allow them to dedicate time to system leadership.

One in five said they did not have enough time to engage with their local system alongside their primary care role. GPs warned this week of the growing clinical demand they face.

The survey highlighted financial unknowns, including uncertainty over primary care funding after 2024. Primary care leaders also feared placing commissioning at ICS level risked taking decisions too far from local communities, and added to GPs' apprehension over future funding.

Strong primary care representation on the ICS NHS board is needed to ensure funding is not shifted from primary to secondary care to address short-term issues, the report added. Primary care funding should be ring-fenced beyond the current five-year allocation, and greater detail was needed on the potential decisions that could be devolved to place level.

Primary care leaders also warned that existing schemes, such as the Quality and Outcomes Framework and the Investment and Impact Fund – an incentive scheme for PCNs – must be adapted and made more flexible to help focus on the priorities of reducing health inequalities and reflecting the needs of individual communities.

Leaders added that the support for primary care clinicians to link with the wider NHS, which is largely provided through clinical commissioning groups, must not be lost when the new system model is established.

The funds could be transferred into primary care budgets, devolved to GP federations that are supporting PCNs, or directed into PCN development funding, the report said.

The funding given to PCN clinical directors during the Covid pandemic significantly aided collaboration on the vaccine programme, demonstrating the worth of such allocations, the report said.

Ruth Rankine (pictured), director of primary care at the NHS Confederation, said: 'Primary care is the front door of the NHS and carries out 90% of contact with patients, so it is imperative that it has full representation on ICS boards to ensure local communities are offered the best care and services.'

Engagement with primary care leaders remained patchy, she added. 'There is a real desire from primary care leaders to have a meaningful role. However, we need to recognise the context within which they are working and the challenges on their time. They must be given the support they need if the health and care sector is serious about system working, collaboration and focusing on local need.'

The Royal College of General Practitioners (RCGP) said GPs were facing increasing demand pressure and had provided a record number of patient consultations in the last four weeks – almost 13 million – while general practices had also delivered 75% of Covid vaccinations.

RCGP chair Martin Marshall (pictured) said the college's figures showed around half of the consultations were face to face.

'GPs and their teams have been working under unsustainable pressures for many years now and we need to make the job of a GP manageable and fulfilling again so that we keep hardworking and dedicated GPs where they want to be – caring for patients. This is why we need to see urgent action to address the workload and workforce pressures facing general practice,' he said.

HFMA Awards to recognise diversity

A new award from the HFMA will celebrate changes that have made a positive contribution to diversity and inclusion in finance departments.

There is strong evidence that diversity leads to better decision-making. And where an NHS workforce is representative of the community it serves, patient care improves and the overall patient experience is more personalised.

This diversity needs to exist at every level of the health service and in all areas – including patient-facing roles and support functions such as finance.

However, there are clear inequalities in the NHS finance function in terms of representation, especially at the most senior levels, where the stereotype of a white, male director continues to dominate.

Work is already under way to improve diversity within NHS finance.

However, NHS England and NHS Improvement chief financial officer Julian Kelly has called on the function to do more. 'We have got to challenge ourselves to see how we can do better,' he told last year's HFMA annual conference.

'Frankly, the answer is that we need to pull through our talent from women and BAME groups, as well as other groups with protected characteristics.'

The new award will be open to individuals, teams or organisations who have made a difference to diversity and inclusion. It will join the eight regular awards, which are now open for entry (*see page 22*) and will be presented during the HFMA annual conference in December. The full list of awards includes:

- Costing
- Deputy Finance Director of the Year
- Delivering Value with Digital
- Diversity and Inclusion
- Finance Director of the Year
- Finance Team of the Year
- Governance
- Havelock Training
- Working with Finance – Clinician of the Year.

The awards highlight good practice in NHS finance and governance.

News review

Seamus Ward looks at recent developments in healthcare finance

Although Covid-19 continues to affect the health and care sector, the past three months have been dominated by pay, continuing concerns over social care, and plans for elective service recovery as waiting lists lengthened. Politically, there have been national and local elections, and a Queen's speech at Westminster, which included government plans for a new part-integrated structure in England.

There was outrage in many quarters, and disappointment from NHS Providers, as the Department of Health and Social Care recommended NHS pay increases of 1% in 2021/22. In evidence to the NHS Pay Review Body and the review body for doctors and dentists, the Department said health budgets for the year had been set on an assumed pay rise of 1%. It pointed out that the government would increase the NHS pay bill by a further 0.7% due to the abolition of some transitional pay points for Agenda for Change staff in bands 5, 6 and 7. A commitment to maintain the pay of some staff in bands 8 and 9 would add further costs.

The devolved administrations insisted they would not be tied to the 1% limit. In Northern Ireland, finance minister Conor Murphy said ministers would consider the recommendations of the pay review bodies before setting healthcare pay rises for 2021/22. The Welsh government also insisted there would be no 1% cap on uplifts. The Scottish government offered most local Agenda for Change staff a 4% pay uplift for 2021/22. The British Medical Association warned that the latest inflation figures (1.5% in April) showed a 1% award would amount to a pay cut in real terms.

There have been personnel changes in government following May's elections. Humza Yousaf (pictured left) succeeds Jeane Freeman as Scotland's cabinet secretary for health and social care. He will have responsibility for the NHS, including the recovery of services as Scotland moves out of the pandemic, and the establishment of the new national care service. During the election, the SNP pledged to increase NHS frontline spending by at least 20% or more than £2.5bn to support recovery from Covid-19.

Meanwhile, in Wales, Eluned Morgan (pictured) has been appointed minister for health and social services and will focus on NHS recovery and the pandemic response. Vaughan Gething, who had been in the job for five years, has become minister for the economy.

There will be a seismic change at the top of NHS England, as chief executive Simon Stevens stands down at the end of July after more than seven years in the role. Not only has he led the NHS in England over the pandemic, but he has also steered the service through its biggest funding squeeze since the second world war and moved it towards a more integrated, collaborative model.

Lessons must be learnt from Covid-19 to better prepare the UK for future emergencies, the National Audit Office said in a report on the initial phase of the pandemic. The government has promised an inquiry into the Covid response next year, but in the meantime the NAO found that the UK was not as well prepared as it might have been. The report added that the pandemic had exacerbated existing fault lines in society, including inequalities, the need for social care reform, legacy IT issues, and the

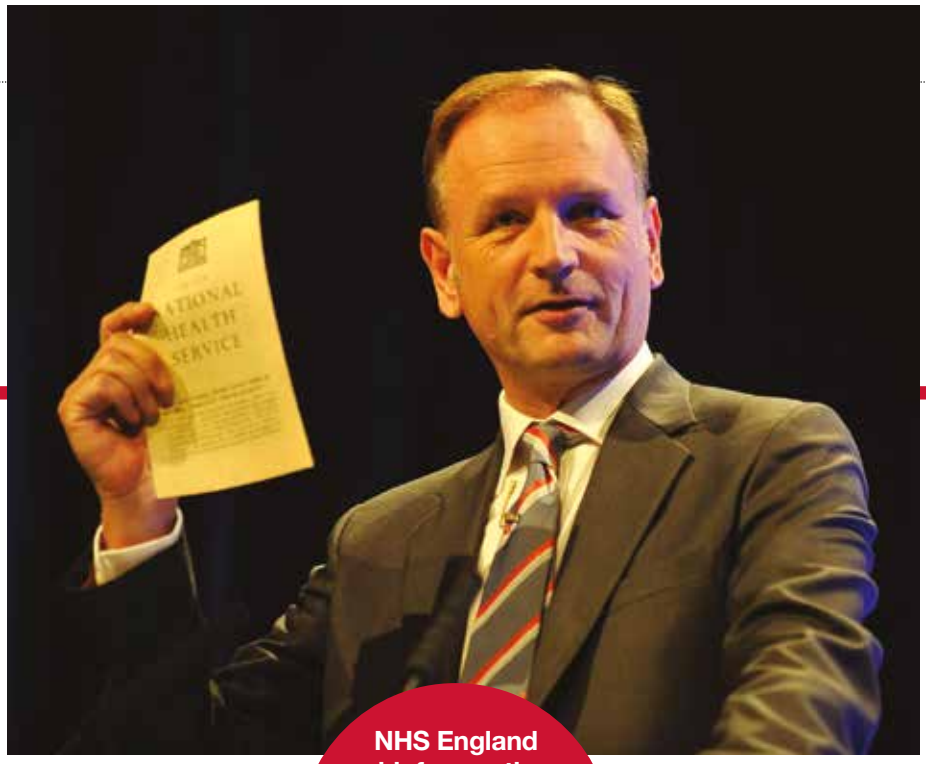
The month in quotes

'I am under no illusions about the size of the task ahead, but it is also important to recognise we now have a real opportunity to transform the delivery of health and care services. The pandemic saw the early and swift adoption of new technology and ways of working. I want to see health boards build on this good work.'
New Wales health minister Eluned Morgan calls for change to speed up the recovery of health services

'It's hard to think of anyone who has had a more profound and positive impact on the NHS in its seven decades. He has also been a huge supporter of innovation, and has given the green light to NHS investment in a wide range of practical clinical improvements.'
Ara Darzi says Simon Stevens' influence is unparalleled

'One of the challenges we've faced are the financial consequences of the pandemic. We've proposed what we think is affordable to make sure NHS people do get a pay rise.'
Health and social care secretary Matt Hancock defends the government's proposed 1% pay rise

'Sir Simon has led the NHS with great distinction for the past seven years. I want to thank him for his dedicated service throughout – but especially when facing the extraordinary pressures of the past year, and for his huge contribution to our vaccine rollout.'
Boris Johnson leads the tributes to Simon Stevens



NHS England chief executive Simon Stevens is standing down at the end of July after more than seven years in the role

financial pressures on local government and the NHS.

The government published its white paper on integrating care – which included making integrated care systems (ICSs) statutory organisations – earlier in the year and its plans were confirmed in May's Queen's speech. It pledged to bring forward a health and care bill that will focus on integration and prevention. The speech, which outlines planned legislation over the coming year, added that additional funding will be provided for the NHS. The backlog of 4.7 million people on waiting lists would be addressed, and 'missing referrals' would be encouraged to see their GP.

NHS performance statistics show five million patients waiting to start treatment at the end of March. NHS Providers warned that full recovery could take three to five years. Chief executive Chris Hopson said that, together with additional government funding, a five-part strategy was needed to clear the Covid-related backlog in a reasonable time period. The five elements of the strategy included: increasing physical and workforce capacity; dealing with bottlenecks, such as investment in diagnostic hubs; making productivity and efficiency gains; reconfiguring hospitals so the NHS can deal with future Covid waves and winter pressures; and rapidly adopting new technologies to treat patients.

Welsh health and social services minister Eluned Morgan outlined plans to kick-start the local NHS pandemic recovery with an initial £100m. The funding will be used for equipment, staff, technology and new ways of working across all health sectors. The minister said it would increase capacity and cut waiting times as non-urgent care resumes. The Welsh government had committed £1bn overall to support its recovery plan.

Health pressure groups and others criticised the lack of plans for social care reform in the Queen's speech. The Commons Health and Social Care Committee warned that ICSs could be destabilised if costed changes to social care are not brought forward soon. Chair Jeremy Hunt said the lack of social care changes was a 'glaring omission' in the government white paper on reform of health and social care. A committee report on the white paper added that greater clarity was needed on the governance of ICSs, including where the lines of responsibility would be drawn between the ICS NHS body and the ICS health and care partnership.

Planning guidance for the NHS in England in 2021/22 prioritises a number of areas, including Covid care, staff wellbeing, cancer and elective services recovery. The current payment arrangements based on block contracts will be retained over the first six months of the financial year (H1). There will be £1bn for elective recovery and £500m for mental health services recovery. NHS England confirmed a £160m initiative to accelerate the recovery of elective waiting lists by piloting new care models in 12 areas and five specialist children's hospitals. The elective accelerators, as they will be known, will receive a share of the funding and additional support to implement and evaluate new approaches to increasing the volume of elective surgery. These will include a high-volume cataract service, one-stop testing, greater access to specialist advice for GPs and pop-up clinics.

from the hfma

A range of blogs in *Healthcare Finance weekly* looked at environmental issues, integrated care system (ICS) governance, social impact bonds, year-end issues, the future of external audit and the role of non-executive directors (NEDs).

Sheffield Children's NHS Foundation Trust finance director John Williams said finance must be at the heart of efforts to implement a net carbon zero NHS by 2040. Post-pandemic, there is an opportunity to consider the shape of the workplace, which could bring environmental and work-life balance benefits, he said.

Chesterfield Royal Hospital NHS Foundation Trust director of finance Lee Outhwaite said creating ICSs was about more than moving functions from one body to another. There will also be big changes in roles and how services are designed and run, he argued.

Emma Knowles, HFMA director of policy and communications, said more clarity was needed on ICS governance and lines of accountability, while Steve Connor, Mersey Internal Audit Agency managing director, said NEDs have a big part to play in the governance of ICSs.

Katy Nex, Social Finance end-of-life care integrator development manager, said social impact bonds could be a way of funding contracts to deliver improved outcomes.

With NHS finance professionals focused on the year-end, the HFMA's Lisa Robertson anticipated a different audit process. While NHS bodies had to take account of new factors, such as temporary financial regimes, she said, the fundamentals still remained the same.

See www.hfma.org.uk/blogs

Comment

June 2021

Discharge duty

The success of discharge funding makes a good case for recurrent support

HFMA president Caroline Clarke

If your health systems are like mine, you will be experiencing very high numbers of patients accessing urgent care. Our emergency departments are busier than ever, primary care colleagues are experiencing huge demand and the words 'but it's only May' have been ringing out wherever I go.

We are also trying to provide as much elective care as possible to try to clear enormous waiting lists.

And you'll be watching what's happening in those areas with higher numbers of people with the most recent Covid variant to see whether hospital admissions are rising.

In my part of London, we are still working on getting vaccination rates up in the general population and in our hospital staff groups. It feels busier than ever, and so important to get the balance of these competing priorities right. Our workforce is tired and scarce – we can't do everything, and we must treat each other with kindness and care!

I've been thinking about what's worked particularly well over the last year. I wanted to write about the discharge funds that were provided to help move patients from hospital beds to more appropriate care settings without getting stuck in a bureaucratic funding nightmare.

That funding significantly helped reduce unnecessary hospital stays and arguably will have helped more patients get back to independence as a result.

I hope that most care systems will be easily able to describe the benefits – and the improved relationships between social and health

Financial designs

The financial framework must be specifically designed to support system working

Healthcare Finance editor Steve Brown

The establishment of integrated care systems (ICSs) as statutory bodies in England will create real opportunities to deliver more integrated care and optimise pathways. But there is a huge programme of work that needs to be undertaken before next April to create the right environment in which these new systems can prosper.

Much of this work is around governance and setting up new organisations. But the financial framework – how money moves around to support greater collaboration and a focus on population health – will also be vital.

There is broad agreement that the 'old' system of payment by results has had its day. In fact, in response to the Covid-19 pandemic, it has already been largely left behind, with block arrangements replacing activity-driven contracts. But NHS England and NHS Improvement have unveiled their plans to introduce a new system – based on aligned payments and incentives – from the second half of this year.

Participants at an HFMA roundtable to discuss the key principles needed in a system finance framework (*see The missing link, page 17*) were clear that any future approach

PRESIDENT'S PLAYLIST

MUSIC I visited the Lake District. It was stunning. And it rained. As we drove up we had a playlist of songs: ***Dog days are over***, Florence and the Machine, for leaving London; ***I'll take you there***, Staple Singers, for Sheffield; ***I'm shakin***, Jack White, for when I got really, really wet round Ullswater; and ***Kelly watch the stars***, Air, for the one evening of gorgeous clear sky.

BOOK I'm enjoying ***Our woman in Havana*** by Sarah Rainsford. She describes what it's really like in Cuba now, from both a dissident and revolutionary perspective. I visited 20 years ago and this is a really balanced account – definitely worth a read and a visit.

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

"It's great that six months of this funding was allocated this year, but what happens after that?"

care as we stopped having non-value-adding arguments about doing the right thing for patients.

It's great that six months of this funding was allocated this year, but what happens after that? It really needs to get backed into the permanent central allocation to prevent us sliding back to pre-Covid, prehistoric times.

And of course, I can't write about discharge from hospital arrangements without pointing out the heart-breaking omission of social care plans from the Queen's speech.

Great news about the extra funding for health, but after the year we've had, and the new status of integrated care systems, we can't avoid the tricky issue of social care reform and finance. Health and social care are inextricably linked and we have to face up to that.

We've held some really good roundtables recently at the HFMA. In this issue, we report on one looking at the system finance framework (*see page 17*). But I had the pleasure of chairing a session with Health Education England talking about how we can get new technologies to really drive value.

We heard from a range of clinical and finance leaders about what was happening in their organisations and systems, and about some of the challenges of both defining and extracting benefits. We also discussed the cultural challenge. New tech and innovation doesn't just land – we are human beings and we need help adjusting!

While this is hard, it shouldn't stop us making progress in this space, and I'd encourage you to have a look at the write-up if you haven't already (***hfma.to/may216***).

Hopefully it will resonate and you will find a way to really innovate in your own areas.

It's final accounts time, and I see my finance team working their socks off to close another extraordinary year. I want to pay my respects to my old colleagues for how they have got their heads down to deal with last year and simultaneously set the operating plans for 2021/22. A year like no other, in many senses. Thank you to each and every person who is involved in both mammoth efforts.

Contact the president on president@hfma.org.uk

should be transparent and simple. There were still concerns about moves to 'blended payment' models, although the centre has now dropped this terminology.

In fact, there may be more agreement about future funding flows than people think. NHS England and NHS Improvement do want a default system that covers all of secondary care. But they are increasingly talking about flexibility and supporting ICSs as they develop local payment arrangements.

And their current proposals are already clear that contracts should over time be based on the local costs of delivering services rather than national prices.

Where everybody agrees is that payment systems must not be an obstacle to systems revising pathways to deliver better care and outcomes, and improve overall system efficiency. But this needs to go hand-in-hand with system oversight that really puts the focus on ICSs.

While there is support for the current year's approach on system oversight, NHS bodies and ICSs are keen to see more detail and understand how the system will work in practice (*see news, page 3*).

The move to systems could also provide an opportunity to rethink financial reporting (*see Technical, page 29*). There is a significant level of variation in how the NHS reports its finances across the country. It can be nearly impossible to make meaningful comparisons of financial reports by different providers, because of the different approaches adopted and often the different definitions used.

Even with clinical commissioning groups – which share a common chart of accounts courtesy of all using the same Integrated Single Financial Environment – it is not always easy to compare and contrast.

And the report published by NHS England and NHS Improvement – a far cry from the detail that used to be provided on a quarterly basis by NHS Improvement for the provider sector – leaves a lot to be desired in terms of transparency.

"Everybody agrees that payment systems must not be an obstacle to revising pathways to deliver better care and outcomes"

While local system boards should have information presented in a format that best helps them to manage local services, there are surely opportunities to take a more standardised approach. At the very least, there could be some agreement on the metrics that all boards should be looking at and how they are presented.

There are real opportunities for systems to start to tackle health inequalities and to focus on population health. Relationships and a real collaborative culture across systems will be key to this.

But the underpinning architecture and governance arrangements must facilitate the new 'system first' mantra. April will come around fast and there is a lot still to do.

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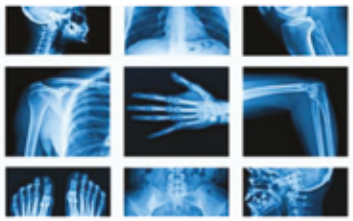


Advertorial Feature

Delivering £1m of Savings In Diagnostic Imaging Maintenance Contracts

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

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

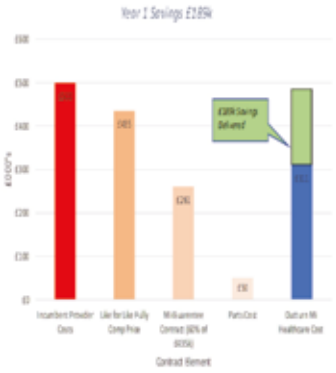
Mi Healthcare, a framework provider, with nationwide engineering coverage have delivered the specified services for c£0.2m per annum less than the hospital's incumbent service providers achieving a 38% saving.

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

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

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

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



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

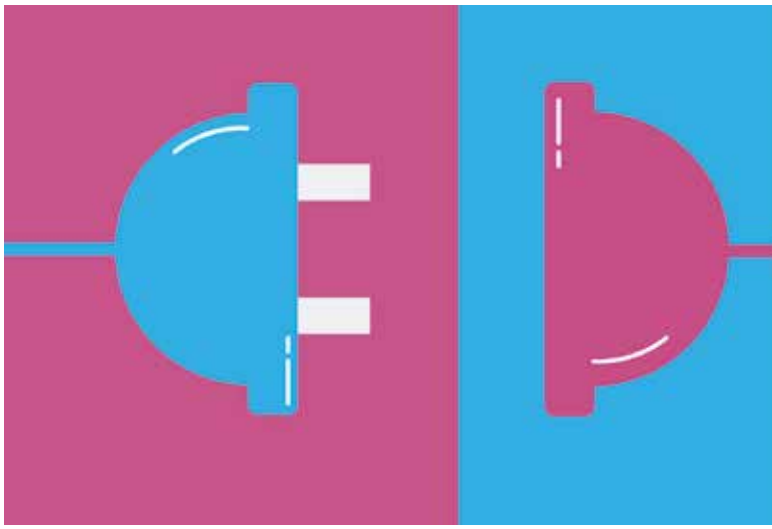
The Mi Healthcare team through the Mi Guarantee contract have delivered this in partnership with imaging departments and will be able to do so for your organisation too. Contractual savings opportunities can be amongst the quickest and simplest to deliver and as a NHS Supply Chain framework provider,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

John Dickinson

Business Development Director

john.dickinson@mihealthcare.co.uk.

Getting connected



There are many benefits of costing and clinical analysis colleagues working together, as costing accountant Clare Speed and clinical analyst Lori Edwards Suarez have discovered. Seamus Ward reports

'I had no idea Clare existed.' So says Lori Edwards Suarez, clinical analyst at Nottinghamshire Healthcare NHS Foundation Trust, of her costing accountant colleague Clare Speed. But, having recently been introduced, the pair are planning a range of projects that will not only dive deep into the costs of the trust's services, but also the quality these interventions produce to give a more rounded view of services to patients.

Ms Speed was equally unaware of Ms Edwards Suarez's clinical development unit, though her team works closely with applied information colleagues to extract patient data for National Cost Collection submissions and the deep-dive reviews. 'As a costing team, we could not function without their continued input,' she says.

There is clearly a natural intersection between costing and the analysis of clinical data, allowing the outcomes of patient care to be linked to the resources needed to perform that care. But even in the same trust, it's possible these connections are not being made.

In the case of the Nottinghamshire colleagues, serendipity played a huge role, with both attending a workshop during the HFMA Healthcare Costing for Value Institute 2021 Costing conference. They were introduced by the institute head of costing and value Catherine Mitchell.

Similar challenges

Ms Speed and Ms Edwards Suarez, who was the Association of Professional Healthcare Analysts' analyst of the year in 2019, faced similar challenges. Both units are small and cover a large trust. Both want to improve the quality of their outputs by engaging clinical volunteers. Both are committed to producing accurate, meaningful information – in itself a way of gaining clinicians' trust.

The costing team had to adapt its processes during the Covid pandemic to ensure it could communicate with clinical colleagues. 'It was difficult at the start of Covid-19 as we couldn't see anyone face to face. However, in the end it worked out better than if we had face-to-face meetings because clinical staff and service managers could join in wherever they were, using Teams,' Ms Speed says.

Both women believe making it easy for busy clinicians is key to collecting good-quality data. For example, the costing team uses data already collected in the trust's patient administration system. 'If you use data already in the system, staff have not had to do anything different, and it has helped push up the quality of the data,' Ms Speed says.

Ms Edwards Suarez adds that the information being collected must be meaningful to clinicians, allowing them to relate the data to their patients. 'If it doesn't work for them, they won't do it and the data will not be collected,' she says.

In some cases, this has meant asking for more clinical detail. Staff have not been put off by additional options in the drop-down lists, which now reflect their day-to-day work more closely, and this has improved the quality of the information.

Ms Edwards Suarez says: 'Both teams were doing similar things. We were looking to improve clinical data, but now we can see what Clare has done successfully, and learn from that. There is a lot of interest in this from clinicians and it would be a shame to duplicate the work.'

Ms Speed takes up the theme. Traditionally, costing in mental health and community services was driven by information required by the reference costs workbook, which concentrated on the efficiency of a service judged by the number of face-to-face contacts that a team completes in a year, she explains.

'A team that produced a high volume of contacts could be considered more efficient if their costs per contact was lower than other teams in the same service. However, this can be misleading. For example, the number of face-to-face contacts during an individual patient's episode of care may show that individual patients are being discharged more rapidly in the team that cost more per individual contact, and thus cost less over the individual patient's episode of care.'

Joining forces with the clinical development unit could add outcomes information to give a fuller picture of what is happening, she adds.

Now they are looking to improve the outputs of both teams through collaboration. 'The clinical development unit is a great resource to link up with, and hopefully we can build something that is good for the trust and the patients,' Ms Speed says.

She continues: 'It's not just about the pound notes. If you get the patient pathway right, that in itself will lead to efficiencies. We need to be able to understand patient pathways and what's working for the patient. We collect a lot of data, but we could do with the outcomes information that Lori's team produces to see how it works in practice, and not just the number of contacts it takes to discharge somebody. It's about doing the right thing with the resources we have.'

It's early days, but the teams are already planning to collaborate. 'Finance has a key part to play, but it's not about saying the patient is too expensive; it's about making sure the interventions people are getting benefit them,' Ms Edwards Suarez says.

- *The Healthcare Costing for Value Institute is holding its Costing revolution summit on 24 November, focusing on the use of costing information and the importance of working with colleagues to turn data into business intelligence. Email josie.baskerville@hfma.org.uk*

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Special delivery

What role have specialist hospitals played during the NHS response to Covid-19? And how can they help with the recovery of services and to address the backlog that has built up? Steve Brown reports

Moorfields

Specialist hospitals are not the first thing you think about when you picture the NHS's efforts to combat Covid-19. But these organisations – from orthopaedic and eye hospitals to cancer centres and children's units – have all been significantly impacted. They have faced many of the same pressures, made their contribution in whole system responses and will have an important part to play in the recovery of NHS services.

Moorfields Eye Hospital NHS Foundation Trust in London is a good example. The provider of specialist elective and emergency ophthalmic services saw more than 780,000 patients in 2019/20 across accident and emergency, day cases, inpatient elective and non-elective and outpatient settings. But in March 2020, as the pandemic struck the NHS, these numbers fell sharply.

'We witnessed something that was unprecedented,' says trust chief financial officer and deputy chief executive Jonathan Wilson. 'We are largely an elective centre and we saw large decreases in activity from the second two weeks in March onwards. And in April the number of case presentations fell even further.'

It wasn't just elective activity that was affected by the pandemic; non-elective work such as vitreoretinal tears also dropped.

A similar phenomenon has been reported by cardiac units. There is an argument that reduced interaction, activity and work by the public during lockdown may have reduced the incidence of some events. But it is also likely that the government's message of 'stay at home' was so effective that some genuine cases simply didn't present.

Moorfields operates a hub and spoke model across London. As the pandemic struck, it temporarily closed some spokes, consolidating its work on fewer sites, and stopped its routine elective work except for P1 and P2 priority urgent and emergency patients.

SHUTTERSTOCK

The focus was very deliberately on sight-saving procedures. However, the overall fall in numbers in April was significant; elective surgery down by 97%, outpatients 82%, A&E 59% and non-elective 36% down.

The trust contributed to the overall NHS response to Covid-19 in three ways. In spring 2020, some staff volunteered to support a number of London trusts, including those hosting Moorfields hubs. In the second wave, a greater number of staff were redeployed, with more than 150 staff moving to support services across London. And the trust worked out what it could do to take pressure off other trusts in terms of ophthalmology services, taking on P1 and P2 activity or providing support to clinicians in other trusts.

But, perhaps of greatest significance, it also took time to think about the recovery that was going to be needed for ophthalmology services once the peak of Covid had passed.

The trust was able to start to recover services over the summer and autumn before the second wave again hit elective activity. And, while the trust has kept sight-saving work going through the year, and turned on virtual and phone appointments where possible, the impact on activity over the whole year is clear.

The trust's figures up to January show that its total admissions over the year fell by 57% compared with the same 10 months in 2019/20. Referrals were down by 53% and total outpatient attendances also fell, by 59%. A&E arrivals were down 38%. This is all contributing to a significant backlog of work – both in terms of cases in the system and those where presentation has been delayed.

Going faster will have to be part of the solution – but we also need to resolve the underlying issues
Jonathan Wilson, Moorfields Eye Hospital

It is not certain how long it will take to recover the overall backlog and it will be different specialty by specialty. For example, Mr Wilson says that, immediately after the first lockdown, some non-surgical subspecialties were forecasting a potential two-year wait for treatment – although this has subsequently been improved significantly by actions taken during the year.

Dealing with this backlog is not a Moorfields-specific problem. A recent report from the Getting It Right First Time programme on cataract hubs and high-flow cataract lists, reports that pre-pandemic cataract surgery activity was nearly 450,000 cases per year and likely to increase over the coming years.

However, it says that NHS England estimates suggest that ophthalmic surgical activity

dropped by at least 38% or 200,000 cases during the year.

The thinking time about recovery at Moorfields led to a number of specific responses. On the surgery side, a 'cataract drive' in September saw the trust quadruple the number of cataract operations in a week to more than 700 across eight theatres at the City Road site.

Diagnostic hubs

And it also developed diagnostic hubs, two of which are already open, with a third in planning. Each hub offers a number of diagnostic lanes containing a number of distinct imaging suites.

So, a patient moves through the lane having their pressures taken, an optical coherence tomography (OCT) scan and whatever else they need, without seeing another patient. The revised pathway reduces both the time each patient spends in clinic to just 45 minutes and the number of overall face-to-face interactions, making the patient journey more efficient.

'We are starting to come back to normal levels of activity in some services,' says Mr Wilson. 'But to get through the backlogs we'll need to do more than 100%.'

This will be difficult given that more than half of Moorfields' activity is undertaken in its Victorian City Road building, which was not designed with social distancing in mind.

Mr Wilson says that, while Moorfields has its own recovery challenges, these need to be seen as part of recovering ophthalmology services across the country – it is after all the NHS's biggest outpatient specialty. Dealing with this general backlog will need to involve more than just typical waiting list initiatives

'We've all been in organisations that have undertaken unsustainable recovery paths,' says Mr Wilson, 'simply throwing extra capacity at the issue.'

He acknowledges that 'going faster' will have to be part of the solution. 'But we also need to resolve the underlying issues.

'We are very aware that there is an option to look at treatments for patients coming through the door – for example, looking at the glaucoma first attendance variation between those who are discharged and those who stay in the system,' he says.

'Some organisations retain those patients while others opt for them to be handled in the community.'

Much of this transformation challenge and the need to explore variation existed before the pandemic. Mr Wilson believes that in some ways Covid-19 has heightened the urgency around this agenda and the trick will be in getting a sustainable match between capacity and demand.

The Royal National Orthopaedic Hospital

The Royal National Orthopaedic Hospital NHS Trust (RNOH) considers itself to be the largest specialist orthopaedic hospital in the UK and enjoys an international reputation for ground-breaking treatment.

One in five of the UK's orthopaedic surgeons has trained there – think bone tumours, spinal injuries, ankle reconstruction and complex peripheral nerve injuries. So its role in the wider response to a major respiratory disease is not so obvious.

However, the Greater London trust not only provided staff for the emergency London Nightingale hospital, but also set up a trauma service, relieving pressure on other trusts in the area and enabling them to focus on their considerable Covid demand.

During the second wave of the pandemic in the UK, the trust even became a general Covid hospital for a short period.

'We shut down our elective work in March, apart from five "life or limb" pathways,' remembers Caroline Owusu-Bennoah, the trust's chief finance officer.

This created the capacity for the trust to reconfigure itself into an emergency trauma hospital – not a service it usually delivers – diverting road traffic accident and other patients away from more seriously affected neighbouring trusts.

'We have a 16-bed critical care unit and the integrated care system [North Central London] recognised our capabilities and our surgeons were keen to help,' says Ms Owusu-Bennoah, who moved from Lewisham and Greenwich NHS Trust to take on the RNOH role in March last year.

'The staff just adapted to becoming a trauma hospital almost overnight.'

Over the ensuing months, the trust admitted nearly 400 patients with trauma injuries. At the same time, the outpatient model was transformed.

Prior to Covid, just 10% of the more than 11,000 consultations each month were being delivered virtually.

This was completely transformed, with 87% of all consultations moved online within the first six weeks, gaining high satisfaction scores in the process (90/100 for patients and 78/100 for clinicians).

While the trust wasn't actively taking Covid-positive patients for direct treatment, it faced similar staffing pressures to other trusts, with staff absences due to illness or self-isolation.

However, it still managed to be a net contributor to the local mutual aid system – not only providing staff for the Nightingale hospital but also helping in other trusts' intensive treatment units when possible.

Ms Owusu-Bennoah says that the trust was doing very little of its usual elective activity during the Covid peak period. There was a period of service recovery in the late summer and the run-up to Christmas. But this came to a halt with the second wave of the virus.

On this occasion, the trust got involved as a step-down facility for Covid patients from local hospitals to finish their recovery before being discharged.

At one point the trust had 68 Covid patients in the hospital – around 30% of the trust's total bed capacity.

Waiting times

The stopping of elective services means a significant backlog has built up, with waiting times inevitably increasing. The trust's referral to treatment performance for the year to February was 66% compared with the target of 92%, although cancer performance has remained strong during the pandemic as one of the trust's protected pathways.

The pandemic has also put the trust's financial recovery on hold. An £11m deficit in 2019/20 on income of £170m marked the fifth consecutive year of not breaking even. For 2019/20, income that was under plan and expenses that were over plan were compounded by a £5m shortfall in Provider Sustainability Fund income.

Ms Owusu-Bennoah says that the problems are long-standing and in part relate to underfunding of the trust's specialist workload via the national tariff, despite the system of tariff top-ups for specialist providers.

But she acknowledges that the trust

THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL

also needs to drive greater efficiency from its operations. Benchmarking with other orthopaedic trusts suggests there are gains to be made.

In addition, the national Getting It Right First Time programme – which started at and has been hosted by the trust – has also identified opportunities that the trust is working through.

Tariff impact

The tariff had a big influence on the trust's income before the temporary finance regime was brought in.

'Specialised commissioning was a block contract, but the basis of the block is activity times tariff and there are certain areas where the tariff doesn't accurately capture the complexity of the work we do,' Ms Owusu-Bennoah says.

'For example, a revision knee is not like a normal knee replacement – it can take far longer – as would the outpatient attendance. So, the orthopaedic tariff doesn't always cover the cost of the treatment provided and the extreme complexity is not captured by the specific healthcare resource group or the comorbidity/complexity splits.'

"The staff just adapted to becoming a trauma hospital almost overnight"
Caroline Owusu-Bennoah, RNOH

She adds that the trust has not yet assessed what a move to aligned payment and incentive contracts might mean for the trust.

The system envelopes issued for the second half of the year set the trust a target of around £800,000 deficit for the year, relying on the recovery of services and some funding through the elective incentive scheme.

Despite the second wave of the virus interrupting the recovery, Ms Owusu-Bennoah says that the trust managed to improve on its target, before an accrual for carried forward holiday is factored in.

As the NHS moves beyond the Covid pandemic and the current temporary financing arrangements, the trust recognises that it has some challenges ahead and decisions to take about the mix of work it undertakes.

'There is room for improvement on efficiency,' says Ms Owusu-Bennoah. 'Doing more standard activity offers more scope for standardisation and, as time goes on, we will need to think about what kind of portfolio we carry out as a specialist hospital.

'The specialist work will always continue, but what else can we do? For example, we have increasingly been talking about musculoskeletal support to the wider system.

'We know the complexities [of this area], so why not support in a wider way by getting involved in MSK as a whole?'

That could mean an increase in non-surgical support and therapy services, and a real opportunity to take a lead role in this area across the whole system.

In general, Ms Owusu-Bennoah recognises that there are real benefits associated with moving to greater system working, but some threats as well – in particular how the move of specialist commissioning to integrated care systems will play out.

NHS England is currently the trust's single biggest commissioner, providing 39% of its total income. Even a small proportion of this funding being spent elsewhere could provide significant challenges.

Golden Jubilee National Hospital

A significant part of the Golden Jubilee National Hospital's role is to keep waiting times down across Scotland – a point underlined by the official name of the health board of which it is a part, the National Waiting Times Centre Board.

As such, it receives referrals from boards across Scotland and typically performs more than 25% of all hip and knee replacements and around 20% of all cataract operations.

It is also a major diagnostic specialist centre, provides all heart and lung surgery for the West of Scotland and manages three national heart and lung specialist services.

However, during the last year, the centre has been relied on even more to keep delivering the country's elective activity, opening an additional cardiac catheterisation laboratory and a six-theatre state-of-the-art eye centre.

The hospital stopped its elective programme when the whole NHS was put on an emergency footing at the start of the pandemic, although it continued to treat urgent heart, lung and cancer patients. However, it resumed planned care at the beginning of July.

Since then it has undertaken nearly 80,000 procedures, including 2,555 orthopaedic procedures, 700 cancer procedures, 4,348 ophthalmology procedures, 6,617 heart and lung procedures and more than 62,000 diagnostic imaging procedures.

Director of finance Colin Neil (pictured), says that the Covid-19 pandemic had brought unprecedented challenges to the NHS in Scotland, as well as to healthcare services all around the globe.

'During this time, however, as a Covid-light site following the initial phase of the pandemic, our team has developed new, flexible, and safe ways of working to continue to provide care for our patients,' he says.

'We have also worked in collaboration with healthcare colleagues across the country to introduce new specialities, including urgent cancer services for those who need them most.'

With the number of procedures undertaken almost doubling since January of this year, Mr Neil says the hospital is playing a crucial role in NHS Scotland's recovery plan.

'We have continued to do everything we can to support the NHS in Scotland as we navigate through the ongoing challenges of combatting coronavirus,' he says.

The missing link

A financial framework that supports system working and behaviours is vital if integrated care systems are to achieve their ambitions. Steve Brown reports on an HFMA roundtable, supported by Newton Europe

HFMA ROUND TABLE

There is widespread support for the move to integrated care systems and a more collaborative approach to healthcare and improving the health of the population. But the simple creation of new organisations and structures won't deliver the desired outcomes. Instead, it will need a new set of behaviours across health and partner organisations and a financial framework that encourages this partnership approach rather than acting against it.

An HFMA roundtable in May, supported by operational improvement specialist Newton Europe, brought together chief finance officers and finance directors from across the UK to identify the key principles that should form the foundation for a system finance framework. And it explored the behaviours that also need to be in place across systems if the new structure is to achieves its goals.

The government recently published its white paper setting out legislative proposals for the move to a more integrated health and care system in England. NHS England has also consulted on a proposed new payment system that moves beyond the old payment by results approach and builds on the temporary finance regime that has been in place since the outset of the Covid pandemic in the UK.

There are also proposals for a system oversight framework to hold systems to account for their performance.

However, while these set out some of the mechanisms that will underpin integrated care systems (ICSs), significant levels of detail are still needed to understand how the full financial framework will operate.

Claire Yarwood, chief finance officer for Manchester Health and Care Commissioning, which brings together Manchester Clinical Commissioning Group with Manchester City Council in a single commissioning body, chaired the day's discussion. She started with a reminder of why the financial framework was important.

'The structures for finance often drive organisational behaviour and sometimes dictate decision-making structures – and this feels wrong,' Ms Yarwood said. 'Governance and decision-making should show the way the finances should flow.'

Underlining her point, she said that the financial strategy should come first with financial management helping to ensure the outcomes are delivered. And the financial framework should support the strategy, not dictate it. She also stressed that the different size and scale of systems would mean they took different approaches to integrating care – and the financial framework had to support these different approaches.

Ric Whalley, a director with Newton Europe, agreed. He said experience working across multiple systems showed why change was needed from the

current framework. 'I've worked with different finance systems and it can sometimes be like pushing water uphill,' he said. 'You often have to put lots of effort into working around the system rather than the system working for you.'

Keep it simple

Transparency and simplicity were two core principles needed in a system finance framework, the finance leaders agreed. Dawn Scrafield, chief finance officer of Mid and South Essex NHS Foundation Trust and finance lead for the Mid and South Essex Integrated Care System, said there needed to be complete clarity about what resources were available for a system. The current contract structure 'encouraged different parts of the system to measure money more than once'.

'You have to spend time taking out the duplication to understand the primary cost of delivering care, otherwise you get mixed understanding and mixed messages,' she said. 'So the key is transparency.'

Emma Sayner, chief finance officer for Hull Clinical Commissioning Group, led calls for simplicity in setting up a system framework. 'We need to keep things as simple as we can,' she said. 'There is so much complexity in the world in which we operate. Wrapping complex mechanistic arrangements around the financial regime will just create more problems than they seek to solve.'

There was a high level of agreement on this point. Jonathan Webb, chief finance officer of Wakefield Clinical Commissioning Group and lead director of finance for the West Yorkshire and Harrogate Integrated Care System, said his system had seen benefits since moving away from payment by results in 2017/18 – replacing it with an aligned incentive approach. This had changed the culture and conversations within the system.

'So, when I see a national approach moving to a blended payment model, my heart sinks,' he said. 'While the theoretical underpinnings of blended payments are fantastic, it doesn't send the right message or encourage the right behaviours.'

(NHS England and NHS Improvement have recently published proposals for an aligned payment and incentive approach to setting contract values for providers. This approach moves away from the language of blended payments and changes some of the approach, although it would still involve a fixed payment based on planned activity and local costs plus a variable element, which initially could be used to support additional elective activity above planned levels.)

Kathy Roe, director of finance at Tameside Metropolitan Borough Council and Tameside and Glossop CCG, echoed the concerns about overly complicated payment regimes.

'This risks undoing some of the way we are trying to focus on driving down costs and driving up outcomes,' she said. 'I'm concerned that we don't link things to the way we've counted and incentivised activity in the past.'

Ms Roe also said she would like to move away from using some language, given its connections to old ways of working. 'While we still need the skills involved, I don't want to be talking about providers and commissioning,' she said.

"Finance systems can be like pushing water uphill. You often have to put lots of effort into working around the system rather than the system working for you"

Ric Whalley, Newton Europe

More fundamentally, she suggested that governance arrangements of those bodies involved with service delivery would need to change as system working took hold.

'I'd be really keen to see directors of public health on the boards of providers, social care directors, lay members or primary care colleagues,' said Ms Roe. 'It has got to start feeling like we are doing something on a system level and understand each other's risks better. Transparency really needs to be fostered.'

System incentives

There was also discussion about the role of incentives, although there was concern about terminology. Mr Webb said any framework had to incentivise system behaviour and performance, and the focus should be on rewarding excellent performance, not punishing lesser performance.

'For example, the Cquin scheme, which took funding away and gave it back if you earned it, felt different to our first year as an ICS where we could earn provider sustainability funding if the system acted together to support each other,' he said. On balance, he thought the shared control total approach encouraged organisations to look at wider system performance.

Ms Scrafield was also keen to see organisations pushed more towards taking a holistic view. She suggested that a system oversight framework that really focuses on overall system performance should encourage providers to look beyond their own walls.

But she was concerned about the possibility of an oversight framework working at both system and organisational level. Providing a 'sub-score' for organisations within the overall system performance could 'create confusion and conflict in the system, because it will drive individual partners to behave in ways that respond to regulation', she said.

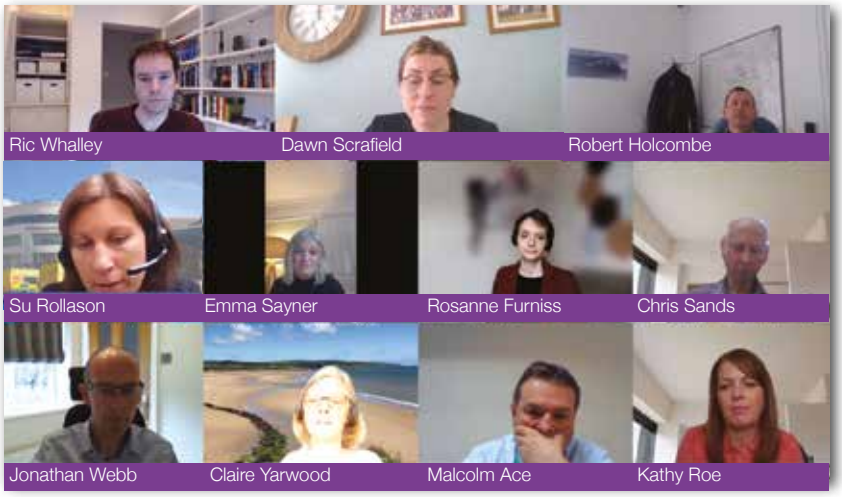
Mr Whalley said as well as encouraging a system-wide perspective, a system finance framework should also encourage NHS bodies to plan and take decisions for the longer term. However, the current annual focus of allocations and financial performance assessment worked against this. Mirroring local government's medium-term financial strategy process would be a step in the right direction.

Su Rollason, chief finance officer of University Hospitals Coventry and Warwickshire NHS Trust, and finance lead of the Coventry and Warwickshire Integrated Care System, agreed that the NHS should learn from elsewhere. There were lots of international health systems with different structures but common challenges. She also underlined the importance of a finance framework enabling systems to take a longer-term view. 'We need to be clear what time horizon we are setting, as it is linked to risk appetite,' she said. 'If you are expected to deliver within a year, it changes your risk approach.'

Mr Whalley also wanted a finance framework to incentivise the empowerment of places, where most integration of services will be delivered. 'Some organisations have enabled the ownership of finances down to a meaningful level, whether that is ward or specialty,' he said. This should be mirrored in systems.

Chris Sands, chief finance officer and deputy chief executive of Derbyshire Community Health Services NHS Foundation Trust, agreed about the importance of place within systems. 'It is also important at place level that we are allocating down to primary care network and neighbourhood level if we want to get the benefits of integration across wider health and social care,' he said.

However, Ms Yarwood said this should stop short of the centre identifying the resources that should go to place level. 'The top-slicing of resources into a lot of national budgets, and then dictating the minutiae of must-dos, takes away the ability of a system to incentivise the right



"Wrapping complex mechanistic arrangements around the financial regime will just create more problems than they seek to solve"

Emma Sayner, Hull CCG

Participants

- Malcolm Ace, Hampshire Hospitals NHS Foundation Trust
- Rosanne Furniss, Newton Europe
- Robert Holcombe, Aneurin Bevan University Health Board
- Kathy Roe, Tameside Metropolitan Borough Council and Tameside and Glossop CCG
- Su Rollason, University Hospitals Coventry and Warwickshire NHS Trust
- Chris Sands, Derbyshire Community Health Services NHS Foundation Trust
- Emma Sayner, Hull Clinical Commissioning Group
- Dawn Scrafield, Mid and South Essex NHS Foundation Trust
- Jonathan Webb, Wakefield Clinical Commissioning Group
- Ric Whalley, Newton Europe
- Claire Yarwood (chair), Manchester Health and Care Commissioning

HFMA ROUND TABLE

delivery at the right spatial level,' she said. 'If funding is ringfenced and tightly defined, this disables systems that have invested and moved at a different pace to others.'

This working to specific national must-dos for specific budgets takes away the ability of local place to influence what is required locally. And the inability to spread expenditure over a number of years constrains localities' delivery of priorities.

Costs not income

There was also agreement that a new framework should encourage organisations to develop a shared understanding of system resources and costs. Ms Rollason said that in the new system world, cost trumped price. Decision-making had to be based on the costs of delivering care and improving outcomes, not the income it attracted.

Ms Sayner was keen to stress that the focus should be on 'the wider resources, rather than pure finance'. 'There should be mechanisms in place to allow the workforce to work across organisational boundaries,' she said. 'That will be far more beneficial to delivering integration than having approaches that move the money between organisations, which can be a significant barrier to system working.'

She called for support to be in place for systems to gain a better, more shared understanding of the fixed and variable costs that are in existence. This would allow costs to be stabilised where they need to be and modelled for what is required, now and into the future, across all sectors, including relevant local authority services.

Ms Yarwood echoed these comments – not having to recharge for staff working in other locations during the pandemic response had been 'incredibly powerful', she said. 'Moving back will increase transaction costs and create all sorts of unintended consequences.'

Mid and South Essex has started to develop such a shared view by pulling together a system operating budget based on costs of delivery. The byproduct of this could become contract sums, rather than these values being decided by conversations between silos across the system.

'We then converted this into looking at service lines across the system– what is the value of the respiratory service line, of frailty or diabetes?' Ms Scrafield explained. 'And we are starting to build that picture. We are now in the process of developing a system budget book, setting out what the resources are by service line.' The aim is to make accountability aligned more to service lines than organisations.

Ms Yarwood asked whether there was still a need for contracts. 'Can't we just allocate money to people who deliver services and jointly hold ourselves to account at the ICS board?' she asked.

Ms Roe agreed that 'commissioning, contracting and procurement are on the way out, while strategy, planning and design are on the way in'.

But Robert Holcombe, deputy finance director of Aneurin Bevan University Health Board suggested that 'commissioning' can add value. 'Moving to more of a planning system approach and the loss of commissioning in Wales lost rigour and removed the grit in the system. External accountability for delivery was lost and we are recovering it now through improved internal scrutiny,' he said.

'I'm not saying you need to have contracts, but you need to have a clear system of holding people to account within the ICS areas. Scrutiny by an 'external' body or partnership rather than an internal management process and the implications of not delivering to an agreement or contract does help promote delivery of objectives.'

Wales already has a higher level of integration than in England, with health boards effectively delivering system working with partners, as part of legislative responsibilities. There were other lessons Wales could offer for partnership working. Mr Holcombe said that despite the health board system, there was still an element of silo working across primary care, mental health, community and acute services. Simply creating a 'system' would not automatically stop silo behaviour.

And he said there were still challenges moving resources upstream out of acute and into the community setting even within a single board

structure. While this might be the ambition, it remained difficult in reality due to financial and service pressures with the need for pump priming to support double running costs.

In addition, he said, there needed to be a recognition that any headroom created in the acute sector would probably be filled, especially given the current backlog. 'So there are not actually pounds to move immediately, however other measures need to be in place to clarify the benefits of service change,' he said.

The Welsh experience with partnership working was that it was important for all partners to have ownership of the joint objective and to be clear over exactly the sum the partnership has control over, he added.

The right behaviours

The roundtable discussed the behaviours that must be developed as part of the move to system working. While the financial framework should encourage transparency, individuals would also have to commit to real partnership working and trust. And 'system first' was as much a mindset as the by-product of payment systems and oversight mechanisms.

'We need to be driven by the principles and the quadruple aim – so it's about population health as much as the money,' said Mr Sands. 'We talk a lot in our system about the Derbyshire pound and we find that really engages people – particularly local authorities.

'And it has helped us to understand our individual and collective financial positions from an incremental as well as a full-cost perspective. That helped to build trust, particularly among the finance directors, around that transparency.'

He added that chief finance officers needed to think about their financial leadership role. 'Having worked in an environment that is very competitive under payment by results, how do we move to a much more collaborative partnership approach and how do we bring our boards, finance and operational teams with us? Examples of where things have worked well through collaboration are really helpful.'

Mr Holcombe underlined the need for the development of mutual trust between partners and the key role finance leaders can have in developing this, suggesting: 'Our finance teams need to be financial ambassadors, not just accountants.'

Rosanne Furniss, a director with Newton Europe, said there needed to be an acceptance that a system approach would mean real funds being moved.

'One of the interesting things I've seen in two large systems I've been working with recently is that one had a focus on getting the financial framework right first and using that to drive the operational behaviour, and the other wanted to get the ways of working and operational behaviour sorted and then have the finance catch up,' she said.

The need for trust and transparency was clear in both cases. 'Where they were trying to get the financial framework right first, the operational team pushed back because they wanted it to be driven by patient outcomes, not finance,' said Ms Furniss. 'But where the operational team set the direction of travel, it then hit a reality boundary – where money had to move from one organisation to another – and it gets blocked at the last minute.'

Malcolm Ace, chief finance officer of Hampshire Hospitals NHS Foundation Trust, said the boards of foundation trusts had to acknowledge they were operating in a different world now.

'Our non-executive directors were recruited into a world where we are dealing with a hermetically sealed population, the finance and performance results are very orientated towards what we do,' he said. 'In future, there must be greater collaboration and a greater willingness to accept a marginal hit on the organisation for the greater benefit of the population.' Addressing health inequalities would often mean a shift in

"Having worked under payment by results, how do we move to a much more collaborative partnership approach? How do we bring our teams with us?"

Chris Sands, Derbyshire Community Health Services

funding flows. He added that these decisions would get more difficult from now on. 'So far, ICSs and sustainability and transformation partnerships have made decisions that are largely win-win,' he said. 'But increasingly these will be "lose" for one partner and "win greater" for the system. We have to find a mechanism in the financial framework where that behaviour is encouraged and allowed.'

System leaders will also need to stand up and be counted at times. Ms Roe said health bodies had to get involved with the wider determinants of health and look to the longer term if they wanted to tackle demand management, which relied on a true system approach.

She described how in Tameside this had involved building a four-year risk-share arrangement. Money flowed from the local authority to the CCG and the acute provider agreed it would bust its control total, missing out on accident and emergency capital funding as a consequence. It took two years for the CCG to get its Qipp target down to an achievable level and the local authority provided some support for the development of the A&E.

'You'd never seen a council support a foundation trust before that, but we managed because we had all the conversations – we had all the members, the GPs and the foundation trust board in the same room, dealing with the same risk and we just cracked a different solution,' added Ms Roe.

Ms Yarwood, who had been finance director of Tameside and Glossop Integrated Care Foundation Trust at the time, said that the bravery and experience of the individuals involved were the key factors in getting a good outcome.

Ms Sayner agreed that leaders needed to show strength of character and not be afraid to take on difficult, albeit constructive, conversations. But she added that 'actions can speak louder than words'. 'Sometimes people can talk system but act differently – we need to be able to have an open environment where this behaviour is discussed. It is not easy, but it is really important.'

Summing up, Ms Yarwood said there was still a lot of detail needed on how a system financial framework would look and operate. There were continuing concerns that the accountability of organisations versus the accountability of systems had not been fully addressed. Language would also be important in ensuring clarity and supporting the development of the right behaviours. And with financial leadership so critical to system success, she encouraged NHS England and NHS Improvement to involve the finance community more, not just with the finance framework, but with the overall governance of the system.

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Covid lessons learnt

Covid-19 threw the spotlight on NHS Supply Chain, especially in the early months. Seamus Ward speaks to interim chief executive Colin McCready about how the pandemic affected the organisation and its hopes for the future

SHUTTERSTOCK

It's rare that NHS procurement is a top story in the national news, but the early months of the Covid pandemic brought story after story of personal protective equipment (PPE) shortages and desperate searches for enough PPE that was quality-assured and offered high levels of protection from the virus. As the national procurement body for the health service, NHS Supply Chain in particular was in the spotlight.

The procurement body was in danger of being overwhelmed, such was the demand for PPE, so a centrally run PPE procurement function was established to allow Supply Chain to focus on all other medical devices and clinical consumables.

This parallel or dedicated supply chain – a partnership that included NHS Supply Chain, the Department of Health and Social Care, the Ministry of Defence, and Clipper Logistics – helped turn around the supply of PPE stocks. It is supported by Supply Chain's PPE buying teams, which are seconded to the government-led unit.

Colin McCready, NHS Supply Chain acting chief executive and chief financial officer, describes the first months of the pandemic in the spring of 2020 as 'incredibly difficult'.

'The reality is that the pandemic planning we had in place was for influenza. Due to the outbreak of Covid-19, demand went through the roof quickly, and required the government to widen the client base from around 200 trusts to 58,000 different settings. At the same time, all the world was demanding the same products largely from the same manufacturers, based in China.

'We did everything we could to get as much in as soon as possible, and to make sure it was distributed as fairly as possible. But we needed something different because of the demand and complexity – and to make sure Supply Chain's core services continued. It needed central control in the early days. We didn't have full inventory visibility of which trust had what.'

Non-Covid supplies

Supply Chain also faced pressure around non-Covid supplies, with staff seconded into PPE work, while some items became difficult to source as manufacturers repurposed their factories for PPE production.

However, Mr McCready feels that, apart from a few weeks early on in the pandemic, delivery of non-Covid supplies remained high. Over the pandemic period it has distributed Covid-related goods to intensive care units, products to kit out the Nightingale hospitals, and supplies to support the vaccination programme.

He is frank when asked if he thinks NHS Supply Chain's reputation has taken a hit, even if unfairly so. 'Yes. I would have to say that even

before the pandemic, we had some goodwill to win back with trusts. It was incredibly challenging on the front line; they wanted products and, in some cases, they didn't feel they got it.

'It was a fast-moving and complicated situation, with everyone trying their hardest to respond to an unprecedented situation. I'm not making excuses – we didn't get everything right, given the size and scale of the pandemic. We have learnt a lot of lessons that we are looking at incorporating into a sustainable model going forward.'

It is hoped that the worst of the pandemic is over, and NHS Supply Chain is looking to the future. A new substantive chief executive is due to be appointed over the summer, and it is working on bringing PPE procurement back into Supply Chain by 1 October. It will run a PPE procurement framework that allows the purchase of up to £5bn of PPE later this year to cover the winter and protect the NHS during potential further Covid waves if needed.

However, the parallel supply chain will continue until the end of 2021/22 to ensure that health and social care providers are not left exposed by a future rise in cases, and to enable moves to a more sustainable future model.

NHS Supply Chain is prepared for demand to return to pre-Covid levels and possibly higher as the NHS works to accelerate its elective recovery work. The rapid adoption of technology during the pandemic showed the possibilities open to the NHS, and Mr McCready says Supply Chain will be working to help trusts bring these advances into the service.

A number of lessons have been learnt from Covid, and will inform changes in pandemic planning across government and the NHS, Mr McCready says. Social care must be supported to the same level as healthcare, and greater understanding of supplies available in each health and care setting, together with the ability to scale up quickly, are vital to ensuring the right products get to the right places on time.

Also, he believes the power of central purchasing for pandemic supplies has been ably demonstrated.

Value-based procurement

Value-based procurement (VBP) is one project central to Supply Chain's future plans. VBP takes a more holistic approach to procurement. Where traditional procurement focuses on reducing product costs, VBP shifts the emphasis to working alongside manufacturers to harness technologies that can improve outcomes for patients and reduce costs across the whole patient pathway.

A Supply Chain pilot study found that VBP can reduce waste and the number of products used; patients previously treated as inpatients can be treated as day cases; infections can fall; and operational productivity rise. 'I think it's clear that it's a really big opportunity for the wider healthcare system, and something we want to actively encourage and support,' Mr McCready says.

Traditional procurement – getting the best product for the lowest price – will remain a key part of the NHS armoury, but it must be enhanced to maintain savings or find ways to avoid costs. 'We need to go after procurement savings – that's always going to be important to get the best value for money. But, given where we are, these opportunities of volume aggregation are going to be diminishing.

'Value-based procurement is different as it allows you to link to the outcomes and look beyond how much it costs. You might pay more, but the patient gets a better outcome or has a shorter stay in hospital. It looks after both prices and outcomes rather than just pennies off the pound, while also building capacity into the system.'

VBP could support the NHS elective recovery programmes. 'It's going to take a lot of effort to bring waiting times down. We are supporting the system by working closely with suppliers to deliver better outcomes, not necessarily the cheapest product, with the patient spending less time in hospital.'

"If the NHS pulls together and breaks down barriers, what can be achieved is amazing"
Colin McCready, NHS Supply Chain

While a switch to VBP might sound straightforward, he is under no illusions about how difficult this will be, especially as it would involve a rethink of traditional cost improvement programme measures and an aligned national system view on how to recognise the benefits.

'This is easy to say, but hard to do. The system is currently set up to deliver in-year savings – that's why we have an important role, asking if the NHS should be measuring value in a different way than it has historically. That requires central support to ensure trusts are incentivised in a different way and over the longer term.'

There are also practical hurdles to overcome. 'Some of the benefits of VBP are hard to quantify and we are working with trusts and suppliers to think about how you quantify and measure the benefits, how KPIs could be written and reported back to the centre when the value is across a whole pathway.'

Mr McCready accepts there is a lot of work to get to this point, but insists it is a huge opportunity for NHS Supply Chain, suppliers and trusts, working together. 'If we have learnt anything from the pandemic, it's that if the NHS pulls together and breaks down barriers, what can be achieved is amazing. The vaccine programme is testament to that.

'We are really excited about VBP. It's hugely important for us and it is something we need to help drive forward with NHS England and NHS Improvement support to develop new metrics and incentivise it.'

As well as having discussions with the centre about efficiency metrics, Supply Chain must persuade suppliers to invest in new technologies and to support the measurement of their benefits.

'Having a close working relationship with suppliers as a central procurement body means we can give them more comfort to take these risks. The NHS has been capital constrained for a long time, so it has to be win-win for both,' says Mr McCready.

Trusts' relationships with suppliers vary, he says, which helps explain why there can be so much variability in the prices paid for similar products. 'As a centralised function, we can build relationships. If something works well, we can roll it out nationally.'

He acknowledges there is a risk of getting too close to one supplier. 'It has to be a competitive market and we must make sure there is tension between different suppliers. However, we have to be able to work closely enough for them to feel it's a partnership and they can benefit financially. You have to walk a fine line, and close relationships don't exclude other suppliers, specifically SMEs.'

Support for the sustainability agenda also comes under the umbrella of VBP, and green measures such as re-manufacturing products could produce that win-win for suppliers and trusts. 'It's a big opportunity

because it supports sustainability at a reduced cost,' Mr McCready says.

But isn't VBP just good practice? 'On paper, it is what all procurement professionals should be doing, but it's easy to say and difficult in practice. Everybody is incentivised to deliver against specific targets, which are based around costs. All procurement professionals would want to do more, but it is difficult in the current environment when targets are around savings. But the momentum for VBP is growing.'

Performance targets

Supply Chain still has a headline savings target of £2.4bn by the end of 2022/23 and to achieve an 80% market share (when Supply Chain was in partnership with DHL, before being brought totally under the Department of Health and Social Care in 2019, its share of the market was 40%). Covid has, of course, hampered its efforts to make savings on behalf of the NHS.

Demand for products not related to Covid-19 care declined last year, but not by as much as expected at the beginning of 2020/21, falling by just over 10%, he says.

'Quantifying the effect on the core business may be difficult as how many opportunities for savings were trusts not able to take advantage of, because they were quite rightly focused on the pandemic. They didn't want to be talking to us about savings.

'In terms of market share, we have slightly over 60%, albeit on a slightly reduced overall market size and excluding PPE.'

He adds that the gain in market share was partly the result of the difficulties faced by some suppliers in sourcing products, which led trusts to turn to Supply Chain.

Mr McCready insists VBP represents an opportunity to make 'some very large savings, as long as there is clarity and understanding of a national methodology for measuring it. This will allow us the ability to look beyond in-year savings to long-term savings'.

Supply Chain has reflected on the way it calculates the financial benefit of its work. 'We have recognised that the methodology we use to measure savings is not the methodology used by trusts. So, we are now doing dual running, and are also tracking customer-based savings.'

For products offered via the Supply Chain category towers, savings are calculated using the prices in place at the start of service providers' contract compared with the current price. For most, the baseline date is May-July 2018.

For trust-based savings, Supply Chain uses the price of the product one year before a purchase as the baseline.

For most transactions, cost price equals sale price, but prices customers pay vary – for example, due to multi-buy arrangements. Supply Chain says that while it is more relevant to trusts to measure savings on the price they pay – sell price – it is more accurate to measure tower procurement activity on the cost price before any margin/discount to customers. Savings in 2021/22 will be measured on the trust methodology.

Mr McCready continues: 'It has been a challenging year for everybody, particularly our customers, and – quite rightly – they were not focused on savings during the height of the pandemic.

'But we have still managed to deliver savings to trusts of just under £65m for the year, excluding what we deliver to NHS England and NHS Improvement for the High-Cost Tariff Excluded Devices programme.' Overall, Supply Chain has been able to save the NHS £250m in the last financial year (calculated using NHS Supply Chain's trust savings methodology).

He says this is one of the areas where Supply Chain hopes to build back the goodwill of trusts. 'When we first launched, many trusts didn't recognise the savings and it took away some of the credibility. We have worked hard to create a system to measure savings that trusts understand and we have been working closely with some trusts to ensure it's what they want.'

Supply Chain will also highlight its broader benefits to the NHS. 'We probably undersold ourselves in the early days a bit by focusing on savings that were not recognised by some of the trusts. But they are also paying for quality assurance, delivery free of charge, and invoicing, all delivered through our central funding.

'We want to be more open on costs and value, listen to our customers and adapt to make sure we are giving them what they want. This will be a key part of our business plan for the next year. Customers will be a part of everything. Our priorities have changed – it's not just about savings, but resilience and system support. Our mission is to be efficient, safe, sustainable, and resilient.'

The advent of system working is a positive development for Supply Chain, Mr McCready says, and he wants the organisation to work closely with ICSs. 'You get incentives of scale and it's easier to roll out best practice and ensure everybody has the same level of service and savings. It will change the way we work, and we are working hard to make good relationships with the ICSs. For us, it's a chance to have deeper strategic relationships across an entire regional market and become more efficient.

'It has been a difficult year, but we are proud of the part we've played in supporting the incredible national effort. We know how challenging it has been for our trusts and we are supporting them. Things aren't going to get back to normal any time soon, but I am excited about the coming year. It's a turning point for the business, as we help to make a real difference for the NHS.'

The Covid pandemic clearly affected Supply Chain, as it has all other parts of the health service, but as the NHS returns to something like pre-Covid normality, it now sees its role differently.

"I am excited about the coming year. It's a turning point for the business, as we help to make a real difference for the NHS"
Colin McCready, NHS Supply Chain

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Support plans

HFMA director of policy and communications Emma Knowles sets out how the association's policy and technical team will support members over the coming year

Every year HFMA's policy and technical team produces a work programme setting out plans for the year ahead. This is developed from conversations at the HFMA's various committees and groups and our aim is to cover the topics most relevant to our members and key stakeholders.

We address those topics through a range of different outputs, including our traditional briefings, consultation responses, webinars and conferences, blogs and articles – and the most recent addition to our portfolio of activities – the HFMAtalk podcast.

We recognise that the volume of relevant guidance issued by NHS England and NHS Improvement, the accountancy institutes and the thinktanks is vast and that our briefings contribute to the length of your reading lists. Our overall aim is to produce short and timely outputs in a range of formats that summarise topical financial and governance issues and provide practical guidance for members.

When considering the topics for our work programme, there are a few things we keep in mind, including whether it meets the needs of members or would benefit from joint work with a partner organisation.

During the year ahead there will be no shortage of areas for us to focus on. As usual, we will keep some flexibility within the programme, but summarised here are the areas that are already top of the list to tackle.

Post-pandemic

Reset, restore and recovery are three words being used to describe what needs to happen to the NHS as a result of the Covid-19 pandemic. Whatever your preferred r word, there is a role for finance staff.

From an NHS finance perspective, there have been huge temporary changes to the financial regime. In some ways, the pandemic gave a welcome break from traditional concerns about the financial position, but that won't last. As we move back to more traditional financial flows, we must continue to keep what worked well – for example, a simpler financial regime, increased collaboration and faster pace of change. We will look at how we can best help members to support their organisations to restore services in the months and years ahead, and learn from what has been working well.

Examples of outputs from the 2020/21 work programme

Integrated care systems

At the same time as post-pandemic recovery, the NHS faces structural change. Assuming legislation progresses as planned, in April 2022 we will see the demise of clinical commissioning groups, with integrated care systems (ICSs) established as statutory bodies.

There is a lot to do to set up appropriate governance and financial arrangements at system and place level. While some systems are quite advanced in their thinking, others have a way to go. The statutory ICSs will be complex organisations, with a statutory ICS NHS body taking on overall system leadership, supported by an ICS health and care partnership (perhaps in the form of a statutory committee). With the support of the HFMA's System Finance Special Interest Group, we will provide guidance to members on the transition to these bodies and share good practice to avoid reinventing the wheel. We'll be thinking about the role of provider collaboratives, primary care networks and local authorities – all key to supporting proper integration.

And we will also be looking to support CCG finance colleagues as they transition into new roles. We have delayed our biennial report, *The NHS finance function,* until next year, with the Skills Development Network census being carried out at the end of June 2022.

This will give us a timely view of the impact of the structural changes on the shape of the finance function just a few months after their creation. While there will be a delay in the production of our provider diversity metrics, during 2021/22 we will continue our work on diversity and inclusion, most notably with a new HFMA award (*see news, page 5*). And we will continue our sector-specific work on mental health and community services.

Health inequalities, prevention and population health

For many years we have talked about health inequalities and preventing ill health. Covid-19 has brought these issues into sharp relief. The role of finance staff in determining the benefits of investing in prevention to tackle health inequalities will be a key focus for the HFMA during the year ahead. We'll be looking at why these issues are important, how finance staff can help and making the case for investment.

Delivering value with digital

Even before the pandemic, the NHS was facing increasing demand. But Covid-19 has compounded the situation. One solution is increasing the use of digital healthcare, including digital medicine, genomics, artificial intelligence and robotics. These technologies can enable people to manage their own care, predict individual disease risk and personalise the management of long-term care. This can also reduce waste and improve value.

But there are challenges for finance staff. How do you make the case for investment and measure success? We will explore any financial barriers and how they can be overcome. Our

work will begin with a short guide for finance on digital technology and the language used.

Financial reporting

We will continue to support members in the production of the annual report and accounts and monthly financial reports. During the summer, we will conduct a 2020/21 year-end survey to learn lessons for next year. And we will support members in meeting the requirements of the IFRS16 accounting standard on leases, which will finally come into effect from 1 April 2022.

We are also planning to focus on how to improve NHS board reporting – what financial information do boards need and how reports can be made easier to understand.

Governance and audit

Our prime governance focus will be on setting up the new statutory ICSs. But we will also continue to monitor the external audit market. Earlier this year, we raised concerns that some NHS organisations were struggling to appoint an external auditor, in part due to regulatory pressures in the auditing profession. Changes have since been proposed for managing local government audits and this will have an impact on NHS audits. We will ensure members' audit market concerns are aired and explore practical options to ensure a smooth audit process.

Environmental sustainability

2020's *Delivering a net zero NHS* report sets out initial thoughts on how to reach the targets of providing net-zero carbon care by 2040 and zero emissions across the entire NHS by 2045. This implies a rapid decarbonisation of NHS activities and we will explore how to embed sustainability within NHS decision-making, focusing on the role of the finance function.

Value and costing

Our work on value and efficiency will continue to form an important part of our programme. This year we will be focusing on the proposal to move to more frequent cost collection, why costing remains important in light of changes to the payment system and improving value at system level.

Communication is a key part of the success of our work and whether it has impact. Since

the beginning of the pandemic, we have changed our offering to members. *Healthcare Finance* has turned into a quarterly printed publication with less of a focus on news stories. The Friday *Healthcare Finance weekly* email highlights enhanced online news coverage as well as the popular news alerts, while providing links to new briefings, podcasts and blogs.

Over the summer, we will be asking for your views on how we communicate with you and this will cover our emails, the myHFMAapp, the HFMA website as well as *Healthcare Finance*. We'd be really grateful if you could spare the time to complete it as it will help to shape some changes over the next few months.

As usual, there will be plenty to keep the HFMA policy and technical team occupied during the year ahead. We will continue to flex our work to best meet the needs of members, so do please get in contact with me if you have any views on our plans.

• ***emma.knowles@hfma.org.uk***

hfma
professional lives
Events, people and support for finance practitioners

What will financial reporting look like in new integrated care systems?

Technical

The NHS bill, announced in the Queen's speech, will turn integrated care systems (ICSs) from a way of meeting the aims of the *NHS long term plan,* despite the legislation, into statutory bodies in their own right, *writes Debbie Paterson.*

The timescales are tight because, if all goes to plan, the new bodies will come into being on 1 April 2022.

Less than a year is no time at all to get the complex new governance arrangements in place. The temptation will be to roll over existing arrangements from either clinical commissioning groups or the shadow arrangements that the ICSs are putting in place. But that should be resisted.

In terms of financial reporting, the new organisations will continue to use the Integrated Single Financial Environment (ISFE) that is used by NHS England and NHS Improvement, as well as all CCGs.

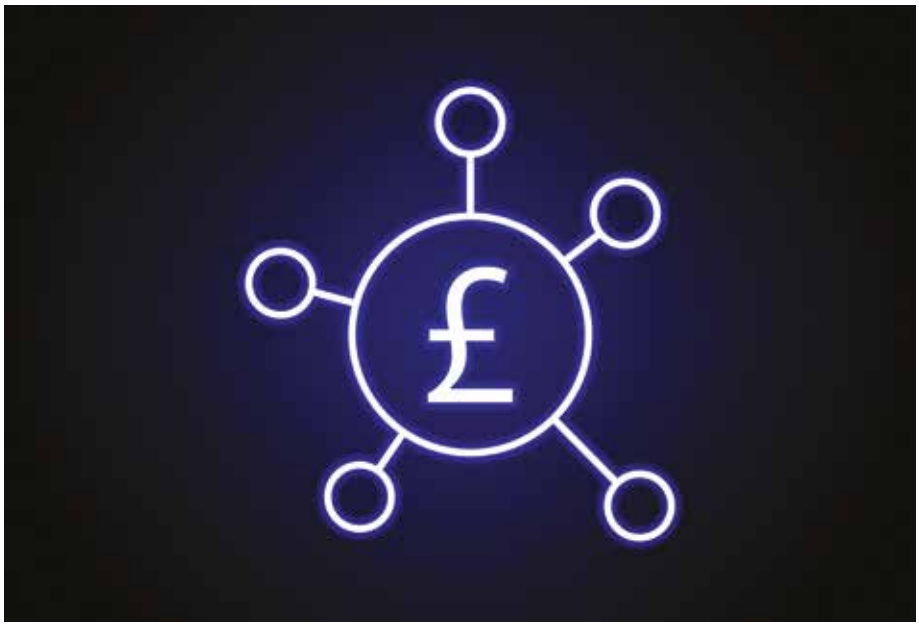
The annual accounts may well look very similar to the ones currently produced by those bodies. However, this is the time to ask whether there is room for improvement.

Note 4 of the NHS England consolidated annual accounts for 2019/20, reports that of £122bn spent on supplies and services, more than 60% has been spent on services from NHS foundation trusts and NHS trusts.

It may be helpful to at least understand what type of services they were spent on, so it is possible to see how much has gone on acute, mental health and community care.

In the longer term, this audited analysis could be used to assess whether the *NHS long term plan* aim to move care out of hospital into the community has been achieved or not.

When it comes to financial reporting, it is tempting to start with the familiar. But is this the opportunity to start with a blank piece of paper and think radically? And if so, what are the questions that should be asked when filling in that paper?



SHUTTERSTOCK

The white paper and the *NHS long-term plan* both focus on the aim of making planning and delivery of services more straightforward across organisational boundaries, as well as focusing on population health needs to improve lives and life chances.

To support this shift in focus, financial information will be needed to help boards understand where the money is being spent and what the outcomes of that investment are.

Does this mean that financial reports should be structured to provide information on the resources spent on initiatives to improve population health, the cost of health inequality and the savings made by changing patient pathways? And, if so, how will that information be collected in the ledger?

Initiatives such as programme budgeting or NHS RightCare provided some of that information – is this an opportunity to hard-wire the financial data collection into the ledger?

There has been a growing recognition of the importance of patient-level costing in recent years. But, while there are notable exceptions, the bulk of the progress has been within acute organisations.

There is still some distance to go before we get a handle on the costs of complete patient pathways, which is vital to the whole integration and transformation programme.

The proposal to move cost collections from an annual exercise to a quarterly one makes sense from the point of view of starting to use this information in something more like real-time. But the national collection is resource-intensive and currently requires data to be submitted in a different format to that used locally by many trusts. With a blank piece of paper, it would

continued overleaf

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seem sensible to harmonise the way costs are reported to reduce the administrative burden for provider bodies. The NHS is not one body but many different bodies with differing aims and objectives. At one end, it is expected that a lot of the detailed planning will take place at place level – so will financial reports be needed for each place? If, as the white paper suggests, commissioning is delegated to places aligned to local authority boundaries, then how is that information going to be collected and reported?

It is unlikely that all commissioning, particularly for more specialised services, will be at place level. So financial information will need to be cut in different ways depending on the arrangements in place. The proposals are that ICSs will have the flexibility to operate locally in the way that best supports the needs of their population and this is expected to develop and change over time.

Unfortunately, charts of accounts are not hugely flexible and are difficult to change once they have been developed. The pressure is on to devise a financial reporting system that can provide information in different ways to different users without an army of finance staff devising spreadsheet workarounds.

So, there needs to be local flexibility. But most NHS bodies (and non-NHS bodies) will work across more than one ICS – particularly ambulance trusts, mental health providers and tertiary care providers. As each of those ICSs will want financial information, it will be important that the requests are not different for each one so that returns can be completed accurately and on a timely basis.

At the other end of the scale are NHS England and NHS Improvement and the Department of Health and Social Care. The information they need to show that national targets have been met and the financial regime is operating as planned is different again.

So, when thinking about financial reporting for the new way of working, the best place to start may be to understand who needs what information and why.

Debbie Paterson is the HFMA's policy and technical manager

Technical review

A round-up of technical developments

Technical

The Ministry of Housing, Communities and Local Government (MHCLG) has published a second response to the Redmond Review on local authority audit. Although the review focused on local authority audit issues, some recommendations will affect the NHS audit market. In this response, the MHCLG is recommending that the new Audit, Reporting and Governance Authority (ARGA) takes responsibility for the regulation of **local audit**, monitoring and review of local audit performance and development of the *Code of audit practice*. These responsibilities will cover local authority and NHS audits. Until ARGA is formally established, the MHCLG will be system leader. The ministry will work with the Department of Health and Social Care, NHS England, NHS Improvement and the National Audit Office, as well as other stakeholders in local audit, while the arrangements for establishing ARGA, including this new role, are progressed by the Department for Business, Energy and Industrial Strategy. hfma.to/may211

Guidance on the finance support and funding flows in the **national hospital discharge fund** has been issued by NHS England and NHS Improvement. The fund aims to help cover some of the cost of post-discharge care, including rehabilitation and reablement, in the first half of the financial year. The document notes the fund could be subject to updates, but in its current form people discharged between 1 April and 30 June will have up to six weeks of funded care, which falls to four weeks for those discharged between 1 July and 30 September. The fund is available to support the costs of new or additional needs and designated care settings for those who are Covid positive. It can only be used to fund care over and above activity normally commissioned by clinical commissioning groups and local authorities. Funding has been allocated to each integrated care system, but held centrally by NHS England and NHS Improvement, with CCGs reimbursed based on actual spend. hfma.to/may212

The HFMA has welcomed the principles set out in NHS England and NHS Improvement's consultation on the proposed **system oversight framework** for 2021/22, but has called for further detail to understand how the approach will work in practice. In particular, it wants to understand more about what is meant by operational and financial system performance, with a definition of 'what good performance looks like' being helpful. In its response to the oversight framework consultation, the association has also called for clarity on how place-based systems will be identified and on how 'failure of an individual provider to collaborate in a system context' will be defined. The HFMA has also responded to the consultation on the 2021/22 national tariff payment system and to the Health and Social Care Committee's inquiry into the white paper on health and social care. hfma.to/may213

NHS England has published guidance outlining all the **system development and IT funds** available to primary care from regions, systems and clinical commissioning groups. The funds include those for workforce growth and development, digital and access programmes, and practice and primary care network resilience and development. It said the funding would be important to help general practice now, as the emphasis shifts to recovery, and in the future. hfma.to/may214

The HFMA's new *Mental health guidance and resources map* brings together key national guidance and useful resources to support NHS finance professionals. The pandemic has put an increased focus on **mental health services** and there is extensive guidance as the government prioritises investment in this area. The new HFMA resource breaks down guidance into separate sections – such as national strategic plans, tackling inequalities, payment systems and currencies, and funding for service developments and capital. The map will be kept up to date as a live reference document. hfma.to/may215

Tutors form cornerstone of online support

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

Training

One of the things that marks out the HFMA Academy's advanced diplomas is the depth of knowledge and engagement from the course tutors, provided online as a more flexible approach to learning, *writes Seamus Ward*.

'The HFMA advanced diploma tutors provide a high level of support, based on years of experience working in senior NHS positions, including finance, and commercial organisations outside the health service. They support students to get the most out of their chosen course,' says academy head Emily Osgood.

Student feedback has been positive. One typical response was: 'Every aspect was well covered, and our tutor was very helpful. She also has very deep knowledge on the various topics covered in the module, which was particularly useful for this study.'

Another said: 'The tutors were very informative, helpful and engaging and always made you feel part of the class.'

Much of the support is provided online. The tutors offer weekly online live and recorded sessions with student cohorts, and interactive discussion forums for questions and debate.

Letsie Tilley (pictured) is a highly experienced NHS finance director, spending more than 20 years at board level. She is lead tutor on the *Advanced diploma in healthcare business and finance* module, *Comparative healthcare systems*.

'Throughout my financial career in the NHS, I have always enjoyed being involved in NHS finance leadership, training and development initiatives,' she says.

'Since becoming semi-retired and moving to live in France, I am delighted to have been able to contribute "virtually" to the content and delivery of various modules offered by HFMA Academy.'

Ms Tilley's approach to tutoring is partly based on her experiences.

'Every week, our learners travel the world, with me as their guide, exploring different global healthcare systems from the comfort of their own homes,' she says.

'I especially enjoy sharing my family's first-hand experience of using the French healthcare system. I also find it interesting researching new material to share with the learners and being involved in their discussions during the weekly online Academy Live sessions.'

Studying at master's level involves learning some great new skills, such as the ability to demonstrate critical thinking, she adds.

'Initially, some learners can find it difficult to master, so it is extremely rewarding helping them to develop those skills and supporting them right through to the successful completion of their assessment assignment.'

Iain Crossley is a tutor on the *Diploma in advanced primary care management*, and has more than 20 years' experience in NHS finance, working as a finance officer, and as an accountable officer.

He has a deep knowledge of, and insights into, system transformation and integration.

Mr Crossley leads two modules – *Personal effectiveness and leadership*, and *Healthcare business and finance*.

'I want to help people understand this thing we call the NHS,' he comments. 'The NHS puts people into roles and expects them to know what to do and how things work. It helps being retired because I can sit back and look at things dispassionately.

'I very much enjoy helping non-NHS finance people understand finance and helping people working at the front line in primary care networks or integrated care systems know what they are looking at.'

As well as tutoring, Mr Crossley has written several of the modules and he contributes regularly to the qualification's online discussion forum, stimulating debate and answering students' questions.

The forum provides valuable support for students. 'It's important to keep the forum rolling because if someone puts up a post or asks a question and doesn't receive a response, they are not going to do it again.'

One NHS Finance gets green light

One NHS Finance

The recent One NHS Finance campaign brought together ideas and feedback on improving the future of the function from 3,200 finance staff across England. This has been developed into a new NHS finance staff development strategy and three programmes, to be launched in September.

Under the new One NHS Finance (ONF) umbrella, three initiatives will be delivered, led by leaders across NHS finance and through the well-established value-makers network:

- Future-Focused Finance – now part of the ONF programme, FFF will continue to build on its initiatives and networks to date
- A new National Finance Academy – which will act as a one-stop shop for finance staff training and development
- A Finance Innovation Forum – which aims to harness the ideas and innovations happening across NHS finance, to roll out more widely across organisations.

These initiatives will be governed by the Finance Leadership Council (FLC) and chaired by Julian Kelly, chief financial officer for NHS England and NHS Improvement.

At the May FLC meeting, proposed delivery plans for these initiatives for the next two years were signed off. The plans, including opportunities for all finance staff, will be launched at the *Becoming One NHS Finance* online event on 23 September. This will include sessions from Julian Kelly and the three new chairs leading the three initiatives under the ONF umbrella – Simon Worthington, Hardev Virdee and Jenny Ehrhardt.

- **Book at www.futurefocusedfinance.nhs.uk/event/becoming-one-nhs-finance**
- **A report sharing the feedback and analysis from the ONF campaign can be accessed at: www.futurefocusedfinance.nhs.uk/sites/default/files/OneNHSFinance%20Report.pdf**

Diary

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

June

9 (B) Wales: VAT level 1, part one
10 (B) Wales: VAT level 1, part two
16 (B) Northern: overview for prospective students
17 (B) Eastern: winning ways – the best practice event
22 (B) Wales: VAT level 2 – VAT in the NHS, part one
23 (B) Wales: VAT level 2 – VAT in the NHS, part two
23 (B) Eastern: meet the branch
23-25 (N) HFMA summer conference
24 (B) Northern: AAT member update
24 (B) Northern: family fun quiz
25 (B) Kent, Surrey and Sussex: building high performance teams

July

5 (B) West Midlands: the highs and lows of homeworking – what is the best solution going forward?
6 (B) London: annual conference
13 (B) Kent, Surrey and Sussex: mini summer conference
21 (B) Eastern: talent management

September

14 (I) Introduction to NHS costing
15 (B) Eastern: social value update
15 (B) Kent, Surrey and Sussex: introduction to NHS finance
15 (H) Productivity and efficiency in NHS providers
21 (H) The changing landscape of commissioning
30 (B) Wales: HFMA Cymru/Wales and ACCA Cymru/Wales annual conference

October

6 (I) International value symposium
7 (H) Workplace wellbeing in the NHS
11-13 (B) Kent, Surrey and Sussex: annual conference
19 (H) Estates and facilities forum
20 (B) Eastern: matrix working
21 (N) Charitable funds
21-22 (B) Yorkshire and Humber: annual conference

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

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

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Events in focus

HFMA summer conference
23-25 June, online

Set across three days, this virtual conference will offer something for the entire finance function, across all NHS sectors. Attendees can expect a varied programme of live streamed sessions as well as a digital exhibition and networking areas to meet with colleagues virtually.

The conference, chaired on 25 June by HFMA president Caroline Clarke (pictured), will bring together all of the HFMA Hub networks including providers, commissioners, mental health and community organisations, as well as those working at a system level.

The programme will be a mixture of national strategic updates from arm's length bodies and various workshops, covering topics such as workforce, technology, resilience, sustainability, value-based healthcare and integrated health and social care. The varied programme will ensure there will be something for everyone.

This conference is CPD accredited and provides an opportunity for finance leaders to ensure their teams are keeping their CPD up to date during these challenging times, as well as providing an opportunity to hear the latest on national policy, learn from peers and meet virtually with colleagues.

• **For further information visit** hfma.to/summer21

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

The conference, which marks the highlight of the year in healthcare finance, will be a hybrid event. The first half of the five-day programme will take place online, while delegates will be able to attend the conference in London during the latter half of the week. All five days will be streamed virtually, allowing the whole finance department to get involved in the entire event. As always, the event promises a mix of technical, educational and leadership content in workshop and plenary sessions.

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

Online packages and face-to-face tickets are available at early booker rates until 25 June.

• **For further details, visit** hfma.to/e8z

Cautious steps back

Association view from Mark Knight, HFMA chief executive

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

My HFMA

Finally! We are seeing some light at the end of the tunnel, with vaccination numbers high and hospital admissions from Covid declining significantly. We need to see the impact of relaxing lockdown measures, but the UK is undeniably in a better place than it has been.

We are all too aware of the pressures on the NHS as clinical colleagues start to address the backlog and restart services. This will not be a quick process and will need investment in people and infrastructure. The HFMA is here to support you with all your issues and my colleague, Emma Knowles, and her policy team are on hand to provide the usual high level of technical support.

The vaccination programme gives us hope – we can be proud as a country in achieving something significant. I've been volunteering at my local vaccination centre and most people are overjoyed to be receiving their vaccine. We need to ensure this high uptake continues into the lower age groups and complete the job.

At the association, we will be taking a cautious step back in terms of our events programme. Our hub events will revert to face-to-face from September, although only a few branches will take this approach in the autumn.

I'd like to put on record my thanks to all our branch and committee heroes who have kept the show afloat. The HFMA is in a much better place now than it was this time last year. We've been able to pay back our staff for their salary sacrifice made at the height of the first wave. I know that you all think our staff are special, because I get lots of comments. I agree!

We're also planning for two big conferences. The summer conference will run virtually this month and then we have our annual conference in December. Please don't delay and get your bookings in as soon as you can. We are planning for a hybrid face-to-face and online event, with a full-scale conference in London. But if we have to limit numbers, then this will be done by giving priority to those who book earlier.

In other news, the HFMA has a new home in Bristol. Our current facility is being closed and refurbished, so we've been on the lookout for new premises for a couple of years. We've found something suitable and have purchased a smaller office directly opposite our current building. HFMA House, as it will be called, will be renovated in line with its grade II listing. It will provide enough space for staff working in a hybrid way, as well as meeting spaces.

HFMA chief executive Mark Knight

Looking ahead I have some exciting news. We already have our leadership lined up for the next two years, with Owen Harkin becoming president in December for 2021/22 and Lee Bond following in 2022/23. But I can now announce that the HFMA board is putting forward Claire Wilson (pictured), director of finance at Wirral University Teaching Hospital NHS Foundation Trust, to be our next vice president (2021-23) and president (2023/24).

That means we now have strong leadership in place for the next three years and I look forward to working with all three presidents for their respective years in office.

The NHS faces significant challenges in the coming years and the finance function will have a major role in meeting them. The HFMA will continue to play its part in supporting you.

Member news

Sarah Robinson (pictured) has received the 2020 Sue Rosson Award from the North West Branch, delayed due to Covid. The annual prize is awarded in memory of Sue Rosson, a graduate of the NHS finance training scheme who died in 1995 soon after starting her career. It is awarded to a student or recently qualified member of finance staff who has contributed over and above their role. Ms Robinson was commended for her procurement work during the pandemic while maintaining her studies, and her support for student groups.

The first Eastern Branch awards were made at its recent conference with the Skills Development Network and FFF:

- Outstanding Contribution – Zoe Pietrzak, director of operational finance and deputy regional director of finance, NHS England and Improvement
- Finance Team of the Year – financial and workforce systems team, East Suffolk and North Essex NHS FT
- Student of the Year – Simranjit Dhinsa, finance assistant, NHS England and NHS Improvement – East of England
- Overcoming Adversity – payroll team, The Queen Elizabeth Hospital Kings Lynn NHS FT.

Colin Forsyth, head of financial services at The Princess Alexandra Hospital NHS Trust, will be stepping down from the Eastern Branch committee and the national Accounting and Standards Committee ahead of his retirement in September. The branch and wider HFMA would like to thank him for his long-standing support.

The Northern Branch is holding a family fun quiz on 24 June from 6.30pm to 8.30pm via Zoom. Tickets are free. For further details, please email catherine.grant2@nhs.net

Member benefits

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

Key contributor awards

The HFMA has recognised the vital support of a selection of its members

GOLD

Nominated by the Northern Ireland Branch, **Kim Ferguson**, branch secretary, is key to developing and managing its annual events programme, including the branch annual conference. She also plays a full and effective role in the wider HFMA family.

Gill Jacobs was nominated by the Kent, Surrey and Sussex Branch (KSS), where she is branch secretary and the longest serving committee member. Passionate about staff development, the branch would not be in the strong position it is in today without her unwavering support.

The Wales Branch nominated **Chris Lewis** for a gold award due to his commitment and long-standing membership of the branch committee. As president, he is the leading voice of the Welsh NHS finance function, and plays an active role in the committee.

SILVER

The Northern Ireland Branch nominated its treasurer **David McMullan** for his role in developing the business case that secured funding for the branch via service level agreements with the Business Services Organisation, trusts, the Health and Social Care Board and Department of Health.

Nominated by Sheila Stenson and the KSS Branch, **Stuart Wayment** continues to play a lead role in organising and administering branch events. He has also engaged in the wider finance community, linking into and promoting the work of Future Focused Finance.

Tim Saunders was nominated by the Eastern Branch for his steadfast support for over 15 years, including looking after the accounts for the past four years. He has a positive personality and is always willing to share ideas and suggestions of how to progress training opportunities.

The Wales Branch nominated **Paula Jones** due to her commitment to and long-standing membership of the branch committee. She is a key member of the committee and is solely responsible for all finance and business planning for HFMA Wales.

Nominated by the West Midlands Branch, **Kevin Stringer** has looked after the branch's finances for many years. A fantastic role model, he has been a constant over the past decade – without him the branch would not have thrived.

BRONZE

David Needham was nominated by the London Branch for his support over the last six years. Though he does not work for the NHS, he is an enthusiastic and committed branch member, covering as vice chair for many years and as chair for a short period.

The HFMA North West Branch nominated **Karan Wheatcroft** as a key member and contributor – linking the branch into CIPFA. She encourages new memberships from her organisation and has been an active member for many years.

Ian Moston was nominated by the HFMA Policy and Research Committee, which he has chaired since 2015. Under his leadership the committee has become the main vehicle for overseeing the association's policy and research activities. More broadly, his support of the HFMA includes events, education and his local branch.

The KSS Branch nominated **Tracy Stickland** for her support of the branch committee and her work as a value-maker, demonstrating passion for staff development in both roles. She ensures members are kept up to date with activities, and promotes HFMA membership locally.

Ken Godber was nominated by the Charitable Funds Special Interest Group, which he has chaired since 2015. A long-standing HFMA supporter, under his leadership the committee has grown, providing sound advice to the NHS community at a time of significant change.

The South West Branch nominated **John Dowell** for his clear direction and unwavering support. An active branch member for six years, he became vice chair in 2015 and chair in 2018, boosting support for students and unqualified finance staff. He is also a member of HFMA national groups.

Thando Moyo was nominated by the Northern Branch for her advocacy of diversity and inclusion. Sponsored by Future Focused Finance, she has set up a network of sponsored colleagues, and is a member of the North East and Yorkshire Diversity group.

Nominated by the Eastern Branch, **Veronica Watson** has worked in the NHS for 35 years (22 as an HFMA member) and is retiring this year. Significant contributions to HFMA include membership of the branch committee and supporting and promoting staff training and development.

Jane Payling, also nominated by the Eastern Branch, has contributed to the association throughout her career. She has 22 years as an HFMA member, supporting the establishment of the branch as the student rep, and has led on a number of successful annual conferences and training programmes.

Annie Walton was nominated by the Northern Branch for her work on the vaccination programme in Newcastle, where she is primary care network finance manager and finance lead at Newcastle GP Services, and for being a One NHS Finance diversity and inclusion ambassador.

The Charitable Funds Special Interest Group nominated **Andrew Machin**, who has made significant contributions to the group over many years. Now vice-chair, he chaired the recent HFMA Charitable Funds conference online.

Appointments

Bob Alexander (pictured) has been appointed acting chair of Imperial College Healthcare NHS Trust. The former deputy chief executive and executive director of resources at NHS Improvement joined the trust's board as a non-executive director in October 2020. He is also currently independent chair of the Sussex Health and Care Partnership Integrated Care System.

Shona Dunn is now second permanent secretary at the Department of Health and Social Care, replacing **David Williams**, who has moved to the Ministry of Defence as permanent secretary. Ms Dunn, who has held senior roles across government, including the Home Office and Cabinet Office, will oversee finance and operations at the Department. Mr Williams has been at the health and care department for six years, first as director general for finance and operations, then second permanent secretary.

Hayley Wardle (pictured) has been appointed executive director of finance at South Tyneside and Sunderland NHS Foundation Trust. She joined the trust in May 2020 as deputy director of finance and has held senior posts at national level at NHS England and NHS Improvement. She takes up the role following the retirement of **Julia Pattison**.

Northern Ireland's Health and Social Care Board has appointed **Tracey McCaig** as interim director of finance. Prior to her appointment she was assistant director of finance at the Northern Health and Social Care Trust, a post she took up in May 2017. She has spent 32 years in health and social care finance, holding a range of senior roles in the NI Ambulance Service, Health and Social Care Board and Public Health Agency.

Surrey and Borders Partnership NHS Foundation Trust has appointed **Lei Wei** (pictured) chief finance officer. She initially joined the trust last November as director of finance, but is stepping into the CFO role to succeed **Graham Wareham**, who is now chief executive. Ms Wei comes from a medical background and is a qualified accountant and project manager. She was previously interim chief finance officer and director of finance at London clinical commissioning groups and integrated care systems.

Terry Whittle has moved to Milton Keynes University Hospital NHS Foundation Trust as director of finance. He was previously director of financial performance at the Royal Free London NHS Foundation Trust, with responsibility for Barnet Hospital, Chase Farm Hospital and for group clinical services. An alumnus of the NHS graduate training programme, he has held senior roles at regional and national level, and is a member of the HFMA Policy and Research Committee. Mr Whittle succeeds **Mike Keech**, who is now chief financial officer at Cambridge University Hospitals NHS Foundation Trust.

Eric Gardiner (pictured) has joined North Staffordshire Combined Healthcare NHS Trust as director of finance, performance and estates. He moves from Betsi Cadwaladr University Health Board, where he was finance director – provider services. Mr Gardiner has more than 20 years' experience working in the NHS. He succeeds **Lorraine Hooper**, who has been appointed executive director of finance, information and estates at Nottinghamshire Healthcare NHS Trust.

North Devon Healthcare NHS Trust and Royal Devon and Exeter NHS Foundation Trust have taken a further step towards integration with the appointment of joint board and leadership teams. **Chris Tidman**, formerly the Royal Devon's chief finance officer, has been appointed deputy chief executive. He joins chief executive and former HFMA president **Suzanne Tracey**, who became chief executive of both trusts in 2018. As well as deputising for the chief executive, Mr Tidman will take on responsibility for estates, programmes, strategy and partnerships, and communications and engagement. **Angela Hibbard** (pictured), who was previously director of finance, performance and facilities at the North Devon trust, has been appointed chief finance officer. She will be responsible for strategic finance management and planning across Northern and Eastern Devon, as well as leading the teams across both sites. The trusts aim to become a single organisation from April 2022.

French takes CEO role

UHS

University Hospital Southampton (UHS) NHS Foundation Trust has appointed David French (pictured) chief executive. Mr French joined the trust in 2016 as chief financial officer and also became deputy chief executive in 2019.

Mr French has been interim chief executive of the trust since November last year, but has now been confirmed in the substantive post following a robust recruitment process, the trust said. A chartered management accountant, he was previously CFO at Hampshire Hospitals NHS Foundation Trust and has extensive experience in the pharmaceutical industry.

He said it was an honour to be appointed chief executive of UHS and was proud of the trust's values and staff.

'I am looking forward to working closely with colleagues in the trust and with our partners across Hampshire and Isle of Wight to ensure we continue to provide world-class care,' he said. 'Together with an ambitious and talented senior leadership team, I am delighted to be leading UHS into an exciting phase of our future development.'

Peter Hollins, chair of UHS, added: 'Throughout his time in the interim role and during the selection process, David has demonstrated exactly the right range of skills to take UHS into the future and at the same time ensure that it plays a leading role in the wider Hampshire and Isle of Wight healthcare system.

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

"Finance professionals have got to act as a bridge between working with clinical teams to provide excellent clinical services and the people receiving them"
Alan Brace

Brace to step down from top Wales post

Alan Brace taking part in an HFMA roundtable in 2018 (above), and winning the Finance Director of the Year Award in 2014 (left)

On the move

Alan Brace is to retire as director of finance for health and social care in the Welsh government, a post he has held for almost five years.

Professor Brace – he is also an honorary professor at Swansea University School of Management – has held a number of high-profile finance and general management jobs in NHS Wales, including a year as interim finance director for health at the Welsh government, two spells as finance director at the then Aneurin Bevan University Health Board and more than five years as chief executive at Carmarthenshire Local Health Board.

A substantive successor is being recruited, but in the meantime, one of his deputies, Steve Elliot, will take the post on an interim basis.

Professor Brace admits he did not start out hoping for an accountancy career. 'I always wanted to be a teacher and I did my teacher training in London, but hated it.'

He thought about following a career in law, but the financial obstacles were too large, so he applied for the local government and NHS Wales finance training schemes. He was accepted into the latter, but feels on reflection that he was more drawn to the NHS than he realised at the time.

A turning point came after Professor Brace qualified. Initially, he spent two years in local government, gaining experience in another area of the public sector and rising rapidly to a senior role. However, on returning to the NHS, the internal market was being implemented.

Two years later, he applied for a trust finance director post. 'I got the job – four years after qualification. My life changed. There were 30 trusts at the time in Wales and that meant there were a lot of senior finance directors I could learn from.'

He felt fortunate, but also excited that in his board-level post he could influence the organisation as a whole.

'On one hand being a finance director so young was stressful, but the opportunity to be involved in the big decisions was a privilege.

Professor Brace, who was named HFMA Finance Director of the Year in 2014, adds: 'I have always worked in well-run organisations that were financially successful as well as successful in other ways. I am hugely proud of that.

'Career highlights that stick with me are those that I helped build, including some private finance initiatives or developing a new hospital. I would also think of changing working practices, the launch of the Finance Academy and new Finance Delivery Unit, and leading the national approach in Wales around value-based healthcare.'

He has been one of the leading advocates for value-based healthcare in the UK, deriving from his support for patient-level costing.

He says that, under a value-based lens, the NHS must listen more to patients and what they want, and not be led just by the delivery of clinically good outcomes.

'We know that a lot of the healthcare we currently provide does not offer any functional improvement to our patients, be that knee surgery or cataracts or cardiovascular services, so why are we doing those operations? Is that the outcome the patients are looking for? It's about a different mindset for finance professionals, who have got to act as a bridge between working with clinical teams to provide excellent clinical services and the people receiving them,' he says.

Professor Brace has long had an interest in healthcare improvement and spent many years developing a business case for quality, showing how it can lead to better use of resources.

He got an opportunity to bring this to fruition when he became finance director at Aneurin Bevan in 2009. 'Due to austerity, we were planning for no growth funding for the foreseeable future, but the board realised we had to use the money we had more efficiently and effectively,' he says.

The stumbling block was a familiar one – how to make a robust business case for quality.

Professor Brace attended a course at Harvard run by value-based healthcare guru Michael Porter and, although he was the only finance professional there – the rest were senior clinicians – this was where it all fell into place.

'We studied outcome measurement to drive better resource usage, and I realised our biggest problem was that we all used the word "quality", but it meant different things to different people.'

There were two sets of outcomes – those that made sense to clinicians and those that meant most to patients. 'Patients wanted less healthcare than we provided in our system,' he adds.

The health board signed up with international outcomes measurement body ICHOM (International Consortium for Health Outcome Measurement), standardising definitions, and began working with clinicians on improvement programmes. The work has formed the basis for the Wales value-based *Prudent healthcare* programme. NHS Wales has recently been chosen by the World Economic Forum as one of its first hubs to accelerate value-based healthcare.

Turning 60 this year, Professor Brace plans to enjoy his retirement and spend more time with his family, while also having the freedom to pick his projects.

'I am interested in working with people who want to change things, and people I would enjoy working with. Finance director is a difficult and stressful job, and there comes a time to hand over to someone with new ideas and energy.

'I always say to new finance professionals that one of their responsibilities is to leave their job in a better place. If we all did this, what an impact it would have on finance in the NHS. I hope I have left with things in a better place.'

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