healthcare finance

June 2022 | Healthcare Financial Management Association

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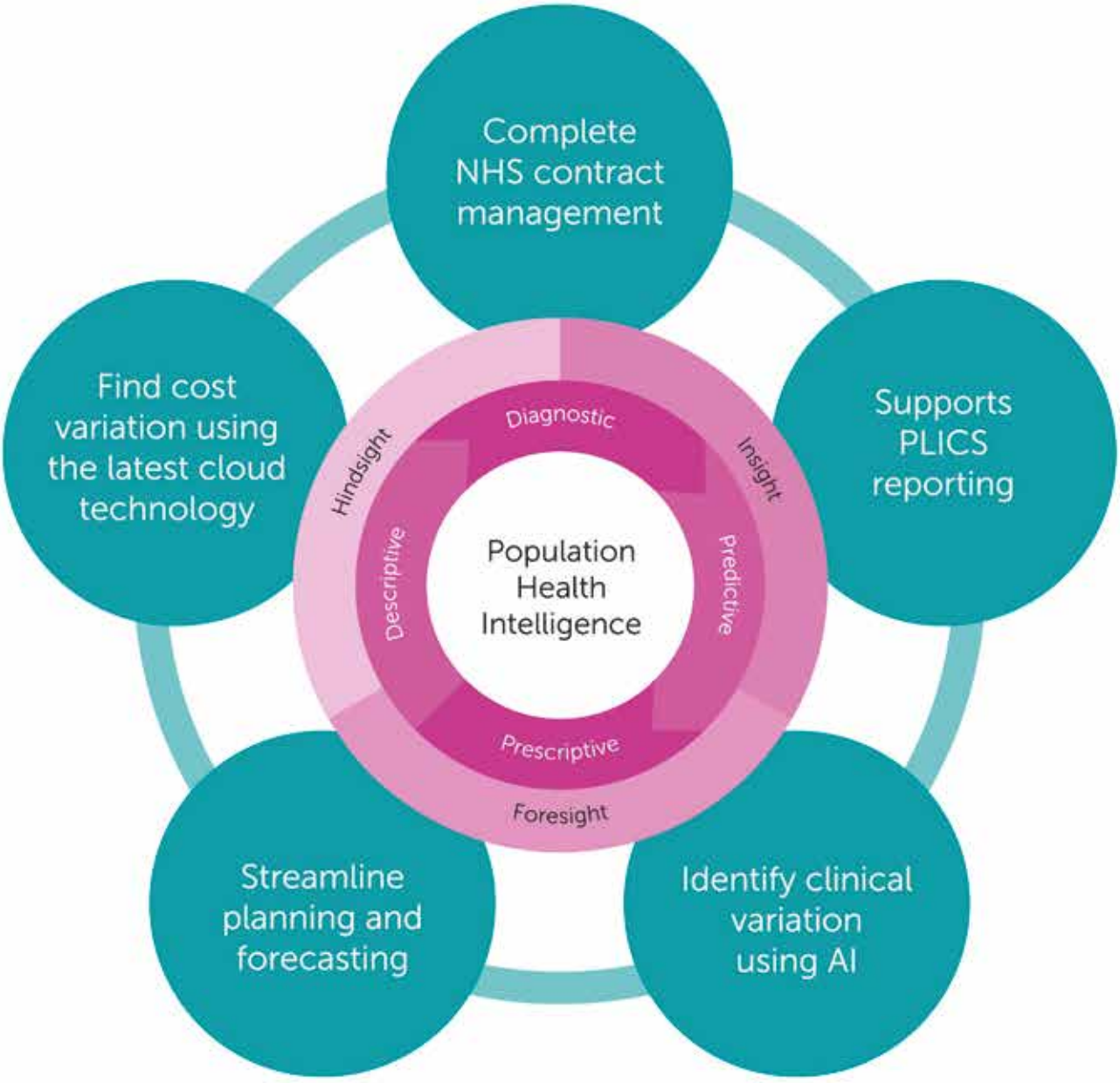

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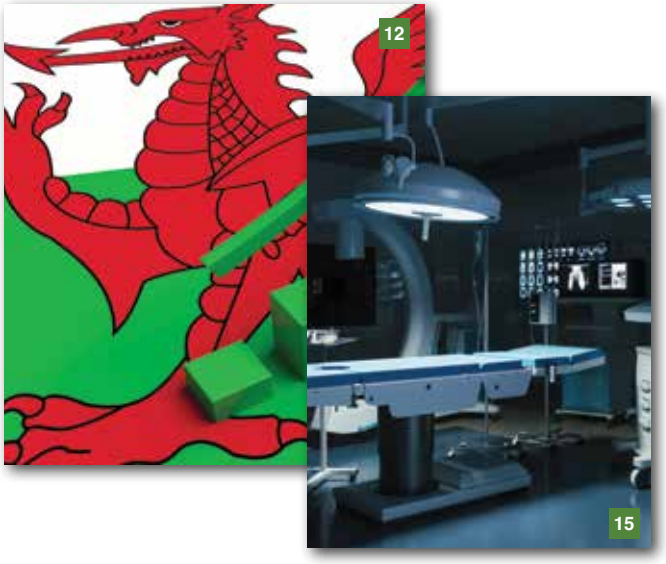

Features

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News

Inflation funding tied to renewed efficiency drive

By Seamus Ward

The health service in England will receive additional funding this year to account for the rise in inflation since the spending review, but systems must agree to a number of conditions.

At the NHS England and NHS Improvement board meeting in May, chief financial officer Julian Kelly (pictured) said systems would get an extra £1.5bn due to the cost pressures. His team had worked with commissioners and providers to identify excess costs, which totalled £1.5bn.

'We are saying to the NHS we want financially balanced plans that deliver the performance and activity goals set out in the planning guidance in December, consistent with the assumptions we set out in December,' he said.

'Clearly one of the things that has really moved since then is inflation, which is running at much higher levels than anticipated in the spending round last November. We've said to the NHS we need to deal with that nationally but, setting that aside, we need balanced plans.'

The operational and financial paper tabled at the meeting outlined some of the cost pressures compared with the December assumptions. These included an extra £485m in energy costs, £350m in care costs related to the increase in local authority-funded prices, and £110m on private finance initiative deals where payments were inflation-linked.

Other pressures accounted for £405m, while additional costs faced by the ambulance service included fuel and the financial impact of the settlement in the Flowers case on overtime and holiday pay, totalling £150m.

In a letter issued following the board meeting, Mr Kelly set out further details on the allocation of the funding. There will be three components:

- Funding for system and regional commissioners to increase the tariff uplift factor, including for providers in other systems and outside the NHS
- Funding in recognition of broader commissioning pressures as a result of higher social care costs, increases in NHS-funded nursing care and better care fund contributions
- Extra money for ambulance services to reflect service pressures, the higher cost of fuel, and the hiring of additional call handlers.

The conditions for receipt of the funds would help the NHS collectively to live within its means. All systems have been asked to:

- Reflect in their plans the cost and productivity improvements as a result of implementing the new infection prevention and control measures and testing arrangements
- Set out evidence for the key lines of enquiry the national bodies have produced for plans
- Ensure plans reflect and commit to delivering recurrent efficiency schemes from quarter three, achieving a full-year effect in 2023/24. This should compensate for non-recurrent measures required to achieve 2022/23 plans
- Engage in national pay and non-pay savings programmes that will be launched in the next few months, including national agreements for medicines and other non-pay purchasing in particular.

A number of control measures that were suspended during the pandemic will be resumed, including the monitoring of agency usage (see page 4), conditions on agency and bank spending, and NHS England and NHS Improvement approval for consultancy spending over £50,000 and non-clinical agency use.

Additionally, systems and organisations will be required to commission internal audit to report to the audit committee based on the HFMA's *Improving NHS financial sustainability: are you getting the basics right?* by the end of August. The report will highlight areas of weaknesses in financial governance and set out remedial actions. By 31 August systems should also review excess inflation figures in their plans.

There are additional controls for systems with a deficit plan, applicable until the deficit is resolved. The letter said that the funding is being made available on the condition that the gap is closed, and reporting and oversight will be increased, possibly including the requirement for central sign-off of new investments over an agreed threshold.

Capital funding for some programmes will be restricted, and the system will be required to produce a detailed workforce analysis.

At the board meeting, Mr Kelly also reported the 2021/22 year-end position, which showed a £1.2bn underspend.

• ***Improving NHS financial sustainability: are you getting the basics right?*** **hfma.to/jun2211**

Specialised commissioning warning

Plans to delegate up to half of specialised services to integrated care boards (ICBs) from 2023 should be handled with care to ensure the move does not increase costs or lower quality, according to the Policy Exchange thinktank.

A report said NHS England should use forthcoming guidance to refine how specialised services will be commissioned under the new system architecture. NHS England currently commissions the services.

The thinktank said big decisions had to be made on the delivery, speed and timing of changes, as well as ensuring financial sustainability. The report's recommendations included highlighting the need to pilot specialised services delegation in a small number of services from April 2023.

NHS England should 'proceed with extreme caution' in moving to a population-based allocation mechanism for the services, and must regularly review the impact of aligned payments and incentives on specialised services contracts. The effect of specialised services should be included in ICB capital and estates plans, it said.

Providers face renewed pressure for compliance with agency controls

By Steve Brown

As living with Covid becomes the new normal, it is also business as usual in terms of efficiency savings. In fact, before the increased inflation cover, some organisations were reporting efficiency requirements of close to 5%. This was a result of the general efficiency demand, the allocations' convergence factor, reduced Covid funding and local pressures.

Reducing agency staff costs – a major focus before the pandemic – is one of the issues that is back on the agenda.

The two-years of the pandemic to date have put extraordinary pressures on NHS staff. There were often heroic efforts from substantive staff taking extra shifts as the workforce was depleted by staff illness or absence due to self-isolation. But bank staff were not always available in sufficient numbers to meet demand and many trusts also had to make increased use of typically more expensive agency staff.

In 2019/20, agency costs amounted to £2.4bn – 4.1% of total employee costs. The 2020/21 NHS provider accounts do not specifically identify agency costs, although they provide a figure of £3.8bn for the more broadly defined temporary staff including agency (£3.5bn in 2019/20). NHS England and NHS Improvement would not provide a figure for the cost of agency staff in the first full year of the pandemic.

However, they have made it clear that this is an area where providers should be looking to reduce costs in the current year.

Financial guidance for the year calls for a reduction in agency staff bills, with workers encouraged back into substantive and bank roles and for moves back towards compliance with agency controls, including price cap compliance.

There have been further calls for trusts to increase options for staff to increase hours through bank shifts to reduce agency reliance. And complying with 'established usage and rate limits' has been made a formal condition for receipt of additional funding to cover inflation increases (*see page 3*).

The key cause of the over-reliance on agencies is a shortage of healthcare staff across the country with 105,000 vacancies. And getting more out of the existing workforce is not necessarily viable.

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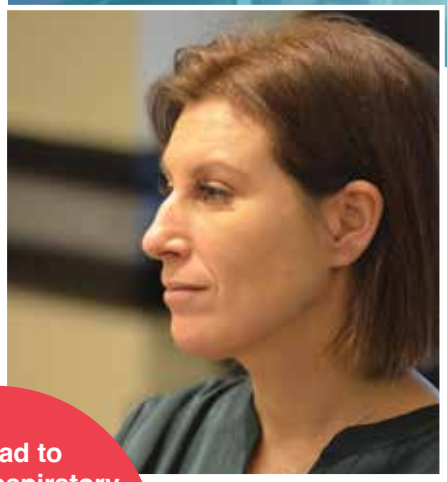

"We had to increase respiratory capacity and we needed staff for diagnostics... and to meet infection control requirements"
Su Rollason

NHS Providers deputy chief executive Saffron Cordery recently pointed to 'high levels of burnout and worrying numbers of staff resigning'.

'We can't keep asking the workforce to simply do more,' she said, repeating widely voiced calls for a long-term, fully funded workforce plan.

Su Rollason, chief finance officer at University Hospitals Coventry and Warwickshire NHS Trust, said Covid had pushed the organisation above its agency ceiling. 'Prior to Covid, we had successfully reduced our agency spend over a number of years,' she said.

In fact, agency spending had effectively been halved. In 2020/21, where elective services were suspended for a period and then operated below normal levels, the trust's agency spend continued below the ceiling. But in the past year, with the recovery programme in full swing and a spike in Covid cases as a result of the Omicron variant, agency spending increased.

Compared with a ceiling of £21m, trust agency spend hit £25m – and this year the trust is targeting spend of £23m.

'We have a vacancy rate of 8.5% and short-term sickness has been up to 8% from a previous level of around 5% - and within that Covid absence has been about 2%,' said Ms Rollason.

'The other issue we've had has been temporary capacity increases such as the need to increase critical care beds, which more than doubled at one point. We had to increase respiratory support unit capacity and we needed staff for diagnostics and testing, and to meet infection control requirements,' she said.

Without complete certainty about what requirements would continue and for how long, it was not always possible to recruit substantively for these positions, even if staff were available. And being an elective recovery accelerator site also increased the use of temporary staffing solutions.

Vacancies differ across the trust – with nursing and midwifery and acute medicine exhibiting big gaps in establishment.

'Vacancy rates are nearly up to 20% in some of those areas,' added Ms Rollason – and this is despite a successful international recruitment campaign for nurses, medics and allied health professionals.

Reducing vacancies is a major priority and as clarity increases over future capacity requirements and funding, the trust will look to substantiate some of the posts it is currently filling with temporary staff.

This year, there is a big focus on reducing staff absence – concentrating on staff wellbeing

and recognising that mental health is the second main contributor to sickness absence.

However, Ms Rollason raised concerns that current increases in the cost of living could create further pressure, with staff opting for higher paid agency roles and rates rising in general.

A finance director at another major acute trust said that higher rates were the inevitable consequence of demand outstripping supply. Squeezing agency spend just moved the spending from agency to bank or overtime, he said. And while there may be a short-term financial benefit, the long-term solution has to be extra staff.

He also voiced concerns that some consultants would leave the NHS in favour of working privately – or reduce their NHS hours. Private waiting lists were growing and, with waiting list initiatives likely to be around for a number of years, he suggested there was also the potential to lose consultants to insourcing contracts.

The move to system working opens up opportunities for organisations to work collaboratively on staffing shortages.

Lancashire and South Cumbria Integrated Care System is a big user of agency and locum staff. Some areas struggle to attract and retain sufficient staff, and Covid, as with many areas, has exacerbated problems with more staff absences needing to be covered.

According to integrated care board director of finance designate Sam Proffitt, the system is keen to move away from its over-reliance on temporary staff. 'It's an issue for quality and it's a significant financial burden as well,' she said.

Parts of the problem can only be addressed over time. The system needs to attract more education and training resource and that means working with universities and others.

But it will also involve ensuring Lancashire and South Cumbria is increasingly seen as a great place to work from professional and lifestyle points of view.

Other things can be addressed more quickly. As with different parts of the country, there will be a shorter-term focus on international recruitment and improving retention.

'There are things we can do like setting agreed rate cards,' says Ms Proffitt. 'But they are not the full solution. We've got to take a single-system approach to our workforce.'

The system is already working more closely together through its provider collaborative and has a system-wide people board in place.

The pressure on organisations and systems to reduce agency spending is increasing. But although finance directors fully support the aim, not all the levers for reducing agency costs are within their control.

ICB chief finance officers gear up for July launch

By Seamus Ward

More than half of integrated care boards (ICBs) have officially appointed their chief finance officers ahead of the 1 July launch date.

As *Healthcare Finance* went to press, 27 of the 42 ICBs had confirmed their lead finance director, though others may have made an offer that has not yet been announced.

The appointments are as designate CFOs until 1 July, when ICBs become statutory bodies following the passing of the Health and Care Act. Under the NHS England and NHS Improvement integrated care system design framework, finance directors are one of only four executives generally required – the others being chief executive, medical director and nursing director.

Some ICBs are more developed than others, though most had appointed a chief executive and chair before the end of 2021. Executive directors, including designate CFOs, cannot be hired before a chief executive is in place.

The North West region has the fewest ICBs, with three covering Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria. All three have appointed designate CFOs – Claire Wilson, Sam Simpson (pictured), and Sam Proffitt, respectively.

The Midlands has 11 ICBs, with five CFOs yet to be announced. Appointed finance directors include Paul Athey at Birmingham and Solihull ICB and Tom Jackson (pictured) at the Black Country ICB.

Unsurprisingly, many of the new system finance leads have been recruited from predecessor clinical commissioning groups, with 16 appointed from CCGs so far. Over the past two years, many CCGs have reorganised governance arrangements to align with the likely ICB area.

Single boards and management teams were introduced, and CFOs appointed. In some cases, the CFOs have been appointed to the new boards, although a number of provider finance directors have also made the switch to ICB finance. These include Ms Wilson and Ms Simpson in the North West, and Steven Course at Norfolk and Waveney ICB.

The three London ICBs that have announced their CFOs have also drawn their designate finance leaders from provider trusts. Nationally, a small number have moved from a regional office of NHS England and NHS Improvement.

Ivor Duffy, chief finance officer designate at Kent and Medway ICB, is joining from Kent and Medway CCG. He said of his appointment: 'It is really exciting to be part of a leadership team that wants to shape and improve health services and outcomes for the benefit of people across Kent and Medway.

'I am also looking forward to the greater opportunity this new role brings for working across organisational boundaries in health, social care and the third sector.'

Steven Course, chief finance officer and deputy chief executive at East London NHS Foundation Trust, spoke of his delight at being appointed director of finance designate at Norfolk and Waveney ICB.

'Throughout my career, I have been committed to putting the patient first, tackling equality and diversity and improving quality,' he said. 'I firmly believe that we have a real opportunity to deliver on these agendas, and more, with effective collaboration across health and care services.

'I am confident that the passion, energy and determination we have in Norfolk and Waveney will ensure we succeed, helping to improve the lives of [local] people.'

Mr Jackson said: 'This is a unique opportunity to shape the local provision of health and care – to reduce health inequalities not only in the Black Country but also to close the gap on inequalities locally compared with those across the rest of the country.

'I look forward to supporting transformation and innovation by focusing resources on areas with the greatest impact on the health outcomes of our people.'

• *See Working in harmony, page 22, and full listing of appointments, page 43*

News review

Seamus Ward looks at recent developments in healthcare finance

The NHS and social care continued to generate stories, but in England the most significant development was the passing of the Health and Care Act. The legislation makes integrated care boards (ICBs) and integrated care partnerships (ICPs) statutory bodies, with both sets of organisations launching on 1 July. ICBs will take over the commissioning functions of clinical commissioning groups, and foster greater collaboration across health and social care bodies (*see Working in harmony, page 22*).

In a letter to the service in May, NHS chief executive Amanda Pritchard said integrated care systems and their partners must focus efforts on recovery and the quality of patient care. ICSs should concentrate on delivering timely urgent and emergency care and discharge; providing more routine elective and cancer tests and treatments; and improving patient experience. She downgraded the Covid pandemic response from a level 4 (national) to a level 3 (regional) incident. A sustained decline in community and inpatient cases meant it was time to reclassify the response, she said, though she also insisted the service must remain vigilant. The full establishment of ICSs on 1 July signalled the next step of reform, Ms Pritchard added.

QUEEN'S SPEECH: HOUSE OF LORDS 2022

The Welsh NHS Confederation said the local NHS needs financially sustainable services if it is to address the effects of Covid and reduce the backlog of planned care. Responding to the Welsh government's plan to reduce elective backlogs, accompanied by an additional £60m over four years to boost recovery and transformation, the confederation said the local NHS needed investment in estates, technology and workforce. This would allow it to try to create a sustainable service in the long term.

Covid and funding are not the only barriers to addressing waiting times. The NHS also needs more staff. In May's Queen's Speech (pictured), the government promised to fund the NHS to reduce Covid backlogs – a promise the Royal College of Nursing dubbed 'hollow' without a plan to recruit more nursing staff. Without a credible recruitment strategy, patients would continue to suffer, it argued.

However, the Nursing and Midwifery Council (NMC) revealed that the number of registered nurses, midwives and nursing associates rose to more than 758,000 in 2021/22, an increase of 26,400 over the year. The number leaving the register is also increasing, with more than 27,000 people leaving – a rise of almost 3,200 (13%). In recent years the number of leavers has been falling. Reasons for leaving in 2021/22 included pressure at work and poor workplace culture. A third of respondents said Covid-19 had influenced their decision – some worried about their health, while others struggled to cope with the increased workloads and lack of staff, the NMC said.

NHS England and NHS Improvement also set out high-impact enablers, including ideas to expand workforce capacity, to support elective recovery. A letter on reducing the elective backlog said it was important to ensure staff are protected from burnout, and are able to take holiday and breaks. It acknowledged challenges in addressing elective waiting times, including the high level of Covid infections. However, it

The news in quotes

'With tens of thousands of vacancies in health and care, nursing staff are facing a losing battle in trying to provide safe and effective care without the staff to do it.'
RCN general secretary Pat Cullen is not impressed with the lack of a workforce plan to bolster NHS recovery efforts

'We know that frail patients tend to occupy hospital beds for a longer period of time and that is why we are expanding the scheme. In reducing the number of prolonged hospital stays, we will free up more hospital beds.'
The hospital-at-home scheme provides real benefits for patients and the NHS, says Scottish health secretary Humza Yousaf

'The legal creation of integrated care boards and partnerships on 1 July is the next step of our reform agenda; it is vital every system partner has – and takes – the opportunity to contribute to making the strategic ambitions of ICSs a reality.'
NHS chief executive Amanda Pritchard urges health service bodies to get behind the new partnerships

'The Health and Care Act is the most significant change to the healthcare system in a decade and will put it in the strongest possible position to rebuild from the pandemic, backed by our record funding.'
Health secretary Sajid Javid says the new legislation will deliver high-quality, joined-up care

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The number of registered nurses, midwives and nursing associates rose to more than 758,000 in 2021/22, up 26,400 over the year

insisted that staff must be given the opportunity to choose to do additional hours. Systems should examine ways of doing this, such as removing the cap on consultant job plans, helping staff to increase their contracted hours, and maximising the use of staff banks. Recently retired staff and those considering retirement could be encouraged to consider supporting training or working in outpatients. The focus on accelerating substantive staff recruitment should remain, it added.

As *Healthcare Finance* went to press, this year's NHS pay rises had not been announced, but with inflation going through the roof, there will be pressure on the government to breach the 2%-3% ceiling it set itself just three months ago. Health unions are pressing for above-inflation pay rises, while junior doctors have said they will campaign for higher pay. In May, doctors in training said their salaries had fallen by more than 22% in real terms over the past decade – they agreed a multi-year pay deal in 2019 that will give them a 2% uplift this year.

The 2022/23 budget for Health Education England (HEE) will rise by £502m compared with 2021/22, the training body confirmed. HEE's overall funding of £5.5bn includes £160m from NHS England and NHS Improvement earmarked for training to support elective recovery and the delivery of the *NHS long-term plan*. The budget includes £2m for the HEE's administration costs, supporting the education body's merger with the new NHS England and increased pension costs. HEE highlighted risks to delivery of NHS training in the coming year, including the focus on service recovery, which could mean that clinical work is given priority over training.

Local government and Northern Ireland Assembly elections took place in May. The latter prompted the Northern Ireland Confederation of Health and Social Care (Nicon) to call for more funding and a three-year budget that must be accompanied by priority investment in the workforce. In its election briefing, Nicon, part of the NHS Confederation, acknowledged issues would not be resolved overnight. But local health leaders committed to using resources to best effect, tackling waiting lists and investing in reform. As *Healthcare Finance* went to press, a new local executive had not been formed, leaving uncertainty over public services funding.

The Scottish government has provided a further £3.6m to expand hospital-at-home services, which offer care to elderly patients in their home rather than in hospital. Patients on the scheme are more likely to avoid stays in hospital or care homes for up to six months after a period of acute illness, the government said. Patient satisfaction is higher, and the scheme takes pressure off NHS beds, it added.

NHS Providers chief executive Chris Hopson (pictured) has been appointed chief strategy officer at NHS England and NHS Improvement. Mr Hopson, who has led the providers' body for 10 years, will leave on 10 June. His deputy Saffron Cordery will become interim chief executive.

from the hfma

More data is needed on the benefits of video consultations, according to Andrew Bone (pictured), HFMA Scotland Branch vice-chair. In a blog on the association website, he discusses Scottish NHS video conferencing service Near Me, which was launched in 2016 and saw a 50-fold increase in uptake in the first four months of the pandemic. Work by the HFMA policy and technical team, commissioned by the Scotland Branch, concluded there was not enough information at clinic- or patient-level to assess whether Near Me generates financial savings, he says.

In a separate blog, Milton Keynes University Hospital NHS FT finance director Terry Whittle says finance staff can create the right environment for innovation by highlighting constraints and challenging thinking. But he believes this could be supplemented by national changes, such as the business case framework, and by allowing the finance regime to develop taxpayer value from innovative partnerships.

Further refinements are needed to the NHS capital regime, locally and nationally, so the NHS has the infrastructure for elective recovery, according to Suzi Joberns (pictured), Wye Valley NHS Trust deputy chief financial officer, and Lee Outhwaite, Chesterfield Royal Hospital NHS FT chief finance officer.

Also on the site, Nuffield Trust senior fellow Billy Palmer looks at how the government is doing in meeting its goal of 50,000 extra nurses by March 2024, and the return on overseas recruitment.

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

Comment

June 2022

At the heart of it

Finance must support integration, population health and equalities agenda

As you know, my theme for 2022 is *Reimagining the future* and we are now at a key stage where the future is presenting some very immediate challenges across England, Scotland, Wales and Northern Ireland.

In England, the NHS is preparing for the 'go live' of 42 integrated care systems on 1 July and work has been ongoing to develop performance and financial plans for 2022/23.

HFMA president Owen Harkin

This is clearly focusing attention on the challenging targets relating to elective care and diagnostics.

And it will also have underlined the importance of collaboration at system and local level to improve flow between hospital and social care settings.

All this is to be delivered within an extremely constrained financial envelope, while coping with the residual and ongoing impact of the pandemic.

In addition, the finance leaders within the new integrated care boards are building coherent teams, drawn mainly from clinical commissioning group finance staff transferring into the new organisations. These teams will need to ensure robust governance and financial stewardship, while looking to the broader agenda of focusing on population health and addressing health inequalities.

While the English restructuring pushes these issues to the fore, the challenges of performance, financial control, system working and population health are, in fact, common across all four UK nations.

More integrated care is a common goal and we must take opportunities to learn from the different approaches being used to achieve it.

All systems go?

Integrated care boards will launch next month in a difficult financial environment

Healthcare Finance editor Steve Brown

The news that NHS England ended 2021/22 with a £1.2bn underspend paints a confusing picture for the public, given wide-ranging reports of extreme financial pressures in the NHS.

In fact, about half of this underspend was in ringfenced Covid budgets, with the main component being the vaccination programme. A further £430m related to ever mysterious 'technical adjustments'.

The reality in 2022/23 is that the financial pressures are very real and the efficiency ask is enormous.

The temporary financial regime that was introduced to support the service during the initial emergency phases of the Covid pandemic has come to an end. And the service has moved back to locally agreed contracts.

The announcement in May of an extra £1.5bn for the NHS on top of the numbers already announced in last autumn's spending review will help (*see news, page 3*).

This is to counter the significant rise in inflation compared with the assumptions underlying the spending review figures, as well as broader pressures. These additional costs have been very specifically calculated and come with a clear expectation that systems will now produce balanced plans.

Even with this funding, NHS systems face major financial pressures. The headline 1.1% efficiency built into allocations and tariff/contract prices is not a fair indication of the actual efficiency requirement facing systems. For a start, there is the convergence factor.

In previous years, the pace-of-change rules simply divided growth up on a differential basis, depending on a clinical commissioning group's distance from its fair share of funding. This year, the convergence policy continues to move systems towards target.

But because the 2021/22 baselines were supported by non-recurrent funding, the convergence factor also brings allocations back within the budget set for the 2022/23 settlement.

Just four systems have positive convergence factors. For the majority, convergence is just a further efficiency requirement.

On top of this, Covid budgets have also

"More integrated care is a common goal and we must learn from the different approaches to achieve it"

The other stand-out challenge facing health and social care relates to workforce. Significant vacancies exist right across the system in a wide range of professions, including medicine, nursing, allied healthcare and social care.

These vacancies contribute to higher costs through use of agency and locums, as well as unwanted variation with increased safety concerns and pressure on existing staff. This has a knock-on impact on wellbeing.

Given training lead-in times, there is no prospect of an immediate influx of newly trained staff, although it is clear we need to understand future staffing needs and ensure we train sufficient numbers to meet those future demands.

In the meantime, we must redouble our efforts to improve retention and international recruitment, and make adjustments to skillmix while keeping a grip on agency costs.

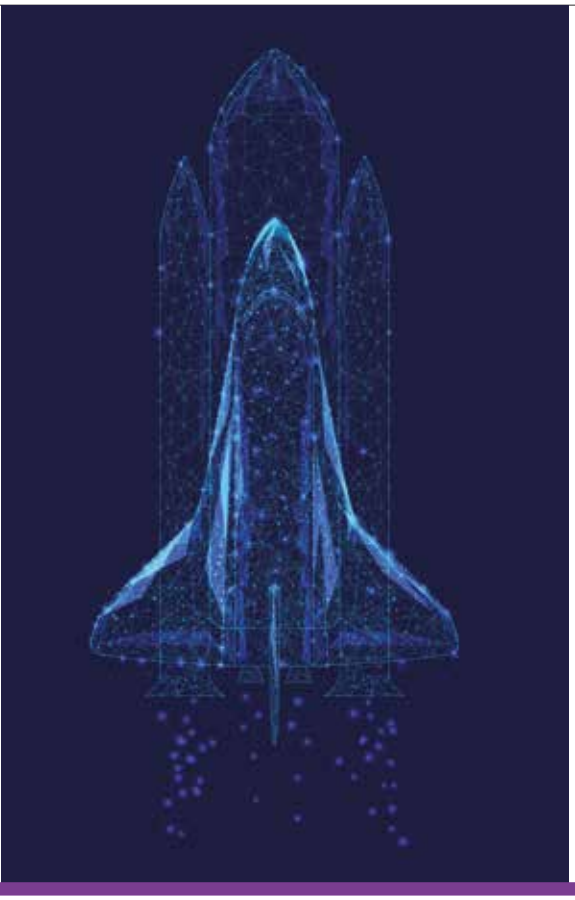
I recently contributed to a panel discussion during a four-nations HFMA Hub event on health inequalities and population health management. It explored four key areas important to these agendas: policy context; resource allocation; prevention; and delivery of care. As part of my four nations initiative for 2022, this was a great opportunity for engagement, with contributions from across the UK to share ideas on tackling this key issue.

I will encourage such UK-wide engagement on a range of common challenges in coming months.

The whole NHS undoubtedly is facing a very busy time and demanding agenda. These challenges do, however, present real opportunities for staff involved in NHS finance teams at all levels of the system. Finance staff have a proven track record of supporting effective and evidence-based decision-making through accurate and timely reporting, sound budgetary control, as well as the ability to identify opportunities to improve value (supported by patient-level cost data).

We will need to apply our skills in new areas – looking at system financial reporting and system-wide value, for example, and putting cost data alongside deprivation and other datasets. But if we get it right, we can make a real difference to cost-effectiveness and outcomes.

Contact the president on president@hfma.org.uk



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been cut. Clearly, this should be in step with reducing costs.

But not all systems have seen the reduction in Covid activity that was assumed in planning. And it is not always straightforward to eliminate the costs associated with some of the Covid response put in place in the last two years.

There have also been renewed calls for systems to bear down on agency staff costs (*see news, page 4*), with controls having relaxed in the last two years.

The whole service would sign up to this ambition. Reducing usage of agency staffing in many situations has both a quality and cost benefit. But use of temporary staff is tightly bound up with the high level of vacancies – 105,000 across England.

The NHS needs to improve retention and international recruitment can help, but the real solution to the current workforce crisis lies in additional staff, which will require serious planning and funding and can't be delivered overnight.

All in all, the financial position provides a very difficult context for the launch of new integrated care boards and the move to system working. Despite this, there is real enthusiasm for system working.

"The real solution to the current workforce crisis lies in additional staff, which will require serious planning and funding"

The public may struggle with the new collection of names and organisations about to be launched – partnerships, systems, boards and places. But the new system leaders (see *Working in harmony, page 22*) remain convinced that a collaborative approach is the only way to tackle the significant issues that are facing the service and to realise some major opportunities to improve services.

Systems will inevitably face the immediate demands of the recovery programme. But the challenge will be to also take strides towards broader ambitions of focusing on population health and prevention and addressing health inequalities.

NEP Cloud,
The NHS' own 'True' Cloud Solution.

NEPcloud
stronger together NHS

Christine Hall, Managing Director, NEP Shared System Group

'Leading and supporting our NEP Colleagues in true collaboration style and driving NHS innovation through technology'.

NEP Cloud is the largest NHS Consortium, offering the only live, multi-org 'True Cloud Solution' combined with the widest range of additional complementary and quality services in the English NHS to date.

Having taken a major step forwards in technology by implementing NEP Cloud for our Finance and Procurement system using Oracle Fusion software, we have already seen how it has positively performed during the Covid19 pandemic, enabling continuity of service for all of its operational processes and reporting timetables.
It is clearly leading the way in terms of the digitalisation initiative of the NHS for all of NEP members and paving the way for the wider NHS.

By maximising the use of the technology and embracing change our consortium members are continually seeing the benefits the technology brings:

- Follows worldwide 'Industry best practice processes'
- Streamlines local processes
- Provides opportunities to make efficiencies
- Enables local teams to work on their own innovations to the benefit of everyone
- Results in savings achieved to be invested back into front line care

All of this is at the forefront of NEP's ethos and is the bedrock of what NEP is all about.

A recent example of our unique consortium collaboration is with our colleagues at Mid Yorkshire Hospitals:

Innovation to implement and develop our Cash Management Module

Our objective : to automate the reconciliation of general ledger items to the bank within the Ledger and not rely upon inefficient manual processes and tools, such as Excel spreadsheets.
Working alongside NEP as a 'pilot' was a successful and joint venture experience, as we have seen the following benefits:

- *All Bank Statements, loaded and reconciled within NEP Cloud*
- *Automated reconciliation of all GL Transactions to the Bank*
- *All Creditor Payments automatically clear*
- *All Debtor cash is cleared as receipting uses a unique reference generated from Cash Management*

Resulting in:

- *Saving resource every day*
- *Improved control environment*
- *Bank Statements being held within our NEP Cloud system*
- *Users having access to 'Live' reports*
- *A significant improvement in staff morale*
- *The team feeling valued as a result of being the first organisation to have such an impact in developing this with NEP*
- *Comments from Internal Audit that this system has improved all our controls and is fully auditable, to see less reliant upon spreadsheets is a great step forward.*

NEP and our NHS Colleagues work well when we work and share experiences together, the enablement of our team having the opportunity to design the process has been exceptional to everyone's benefit

Derek Stewart, Head of Financial Accounting and Control, Mid Yorkshire Hospitals NHS Trust

Despite the pandemic, NEP completed successful implementations in 3 large NHS Foundation Trusts during 2020/21, all undertaken remotely and through the sole use of technology. This clearly demonstrates the flexibility and capability of the technologies available and the drive to make it work.

NEP Cloud Procurement Implementation:

We made a conscious decision to have greater integration between Finance and Procurement utilising our current ERP Cloud provider. As with any implementations, there is always a lot of apprehension, change, and risk associated with it. However, having a strong relationship with NEP in terms of Finance, the collaboration across the Consortium, combined with shared knowledge and learning has helped significantly in our transition.
Across the board, NEP's customer service has been excellent from an amazing team. Without the patience, knowledge, training and determination to support our team, the transition would not have gone as well. We are looking forward to embracing and engaging in further innovations and opportunities the NEP Cloud technology brings to us, particularly in terms of Peppol, whereby this will bring further enhancements and, in some cases immediate savings.

Joan Grant – Corporate Reporting Accountant and Deputy FSD Lead -Blackpool Teaching Hospitals NHS Foundation Trust.

In working with our NHS colleagues during the pandemic, we have seen how well some organisations have managed to deliver enhance services and processes.

> *We all know that during the pandemic all NHS Finance Teams faced many unexpected operational challenges, luckily, through cloud technologies, NEP Cloud enabled us to continue business as usual and enable us to concentrate on the much wider issues of supporting quality patient care.'*
> *'It also highlighted that we could, through embracing what we have available, change the way we work for the better. Therefore, we invested and instigated a large-scale transformational change program within the finance team, undertaking a holistic view of how we could change for the better by maximising the way we work and in the use of NEP Cloud technologies and its offerings'.*
> *In less than 9 months, I am delighted to say our team have embraced changes, owned the process, and are already seeing the streamlining of processes, delivering more benefits and value. Our committed and valued workforce have seen an enhancement of their roles, which we will continue to develop and embrace the technologies we have.*

Paul Dunn – Executive Director of Finance – Northumbria Healthcare NHS Foundation Trust

NEP's additional and unique benefit is having a single set of data on one platform. We have successfully been working with NHS England and Improvement around spend analytics and data standards.

> *We are working with NEP, who have been supporting us in the Spend Comparison Service with AP and PO data loading into our Commercial Data Warehouse. Our project goal is to provide a single source of truth for procurement teams in the country, enabling them to analyse national data robustly-and in great detail - without local and regional limitations. NEP have been instrumental in the project as they cover a large section of procurement spend and they can provide access to the spend data that they manage. Rob and his team have been proactive in developing a working solution that we can use and merge with the data we use from other providers in the country. The best features of the NEP solution are the quick turnaround time – data is showing within a day – and the robust data quality; thanks to the cloud solution they use, there is no manual process in the data extraction and we get instant access to the data we need.*

Levente Fazekas, Spend Analytics and Data Standard Lead at NHS England and NHS Improvement

The work NEP and its partners are undertaking is fundamentally, innovation at its best. Working collaboratively and joining up the dots of the NHS objectives from a technology perspective is not to be underestimated.

Another prime example of coming together is our mandated Peppol initiative.

> *NEP have been, and remain the pioneers of the NHS' digitisation strategy in relation to Peppol, GS1 standards and catalogue provision meaning they provide their membership with the most advanced and future-proofed solutions available within the healthcare supply chain*

Bengt Nilsson, CEO, Pagero

It is clear that where there is technology, it often comes at a cost and at some risk. The unique benefit and value NEP Cloud offers is that all our members benefit from an all-encompassing package at a highly competitive NHS rate. We develop the solution once, and all features are available to our members, either integrally as part of the whole solution or at minimum cost. At NEP the NHS is at the very heart of what we do.

> *NEP isn't just about Technology, it's about how the technology and people are coming together to get us where we need to be.*

Paul Sutton, Head of Compliance – UCLH NHS Foundation Trust

It is encouraging to have such positive feedback from our colleagues across the NHS about the hard work and tenacity the NEP Team, Partners and of course our members, who all have a voice and opportunity in how we shape our NEP Cloud solution. It is a testament to true partnership within the NHS. NEP are so far ahead now in terms of technology in the way we work, it is exciting to see what achievements and innovations we can all make next on our journey to help and support our NHS Colleagues.

Watch this space.

> *NEP continues to evolve and deliver innovation, cloud technologies and services to its NEP Colleagues, the collaboration and progressive attitude of the NEP team, combined with input and ideas from the members, has seen it grow into the most forward-thinking organisation to successfully support both Finance and Procurement objectives in the NHS today.*

Sir James Mackey – Chief Executive – Northumbria Healthcare NHS Foundation Trust

Contact us for any further information;

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Welsh marches

NHS Wales has attracted worldwide attention for its development of value-based healthcare – and now it is focused on taking the programme into the mainstream. Seamus Ward reports

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In recent years, NHS Wales has been developing approaches to healthcare that increase value to patients and deliver better outcomes in the most efficient and effective way possible. Over the past eight years, since the inception of value-based healthcare (VBHC) in one local health board, it has helped define the outcomes that mean most to patients in several clinical areas. It is now focused on bringing VBHC into the mainstream across the nation's health system.

Local NHS organisations have been developing VBHC (see box, facing page), and rolling this out across clinical condition areas. It now seeks to apply it to healthcare pathways across the nation, under the leadership of the Welsh Value in Health Centre and the Finance Delivery Unit.

Having developed a central infrastructure to support the system, the Wales Value in Health Centre, under the leadership of national clinical lead Sally Lewis, has launched its strategy with six areas of support for VBHC:

- Person-centred care
- Digital health
- Implementation across NHS Wales
- Communication, engagement and education
- Impact-delivering value
- Research, industry and strategic partnerships.

Dr Lewis says: 'Prudent healthcare's key principles of co-production, equity, intervening gently (effectively and only as much as we need to) and reducing unwarranted variation, including under- and over-treatment, are all key to achieving value for our patients and citizens across a whole system of healthcare.

'Value-based healthcare pulls together a system of care around a particular patient pathway, where better outcomes at lower cost are achieved by doing basic things really well. It also has the potential to improve outcomes through innovation and quality improvement, and can reassure us about patient safety.'

According to Dr Lewis, the implementation of VBHC is a large cultural and transformational change that has grown from the grassroots in Wales as a delivery mechanism for prudent healthcare.

'The principles are important in underpinning the way we reshape our services to meet the evolving needs of our population in Wales,' she says. 'Realising the full potential of this seismic shift in healthcare is a long-term endeavour. But already we believe that we're beginning to demonstrate results in a diverse range of clinical areas, such as heart failure, diabetes, orthopaedics and lymphoedema.'

The NHS Wales Finance Delivery Unit is embedded in the Value in Health Centre's work by focusing on developing the national approach from a financial perspective to support VBHC and delivering improved patient outcomes.

Hywel Jones, the unit's director, says the value programme has taken significant steps forward, but is keen to stress that it is still far from completing the task.

'We have done a lot of work as a system to get the infrastructure in place around value-based healthcare to support the NHS in day-to-day planning and delivery,' he says.

Infrastructure in place

This infrastructure includes:

- A national programme for rolling out patient-reported outcome measure (PROM) capture and sharing of data nationally
- National costing data collection at patient level and time driven activity-based costing exercises
- A national data resource programme integrating all datasets on a national basis
- A programme of work across local health boards and national functions across a number of clinical condition areas.

'We have made good progress but clearly there's work left to do. The critical point is that we are creating a national framework to develop a consistent approach for developing

this at scale. We also recognise that local populations and factors result in health boards implementing what they need to do locally to deliver a value-based healthcare approach to improve outcomes for patients.'

The Finance Delivery Unit, established in January 2018, is a support function that leads in a number of domains across NHS Wales. These include best practice, financial management, support and challenge to deliver financial improvement, the development of strategic financial intelligence, financial planning, and VBHC.

Such is the progress being made by organisations, and the Welsh government emphasis on the importance of VBHC, that in 2022/23, £20m has been allocated to deliver improvements in a number of areas. These include cost and outcome data measurement, PROMs, resource allocation and distribution, reduction of unwarranted variation, and implementing evidence-based high-value interventions that improve outcomes.

This allocation complements the approach from a financial perspective, where increasingly NHS Wales is exploring how to optimise financing VBHC.

Mr Jones says it is exploring three main areas – how to finance value at an allocative level on a system basis (from government to local health boards), how to allocate resources within organisations across pathways and clinical condition areas, and how the NHS uses its resources with partners, be that purchasing, industry or other public sector organisations, with a view to improving outcomes.

He believes there is no single approach to allocating resources that will increase value but a combination of approaches, which will vary depending on clinical condition and the changes required to improve outcomes.

Practical steps

In practical terms, there are a number of elements to this approach. The first is finance teams working together and directly with national clinical leads to develop the cost and outcomes data using a range of techniques required to identify improvements within clinical condition areas.

'This is about putting finance and clinicians together to interrogate data using a range of techniques in a sophisticated way. The aim is to give clinicians insight into the unwarranted variation and high-value interventions that will improve value and patient outcomes,' Mr Jones says.

> **"We are focusing increasingly on capturing PROMs in a consistent manner, with consistent standards"**
> **Hywel Jones, Finance Delivery Unit**

Through these relationships, the Finance Delivery Unit and the National Value in Health Centre are producing a range of new products to tease out the clinical challenges, and ensure the right information is developed to focus on the actions required to drive value.

These products are increasingly being supported by the advances in collection and integration of a range of datasets. This includes collecting comprehensive PROMs and patient information across Wales, patient-level cost data, population health data and hospital admissions data.

A national data resource (NDR) is being developed to ensure that all of this data is integrated into one data repository and the information is being tested to ensure that the right approach is taken and the evidence base is robust.

Health boards have the autonomy to develop their own approach to meet the needs of their population, but within a common framework and using some of the national data to provide actionable insights at a local level.

NHS Wales is putting a number of steps in place to support the implementation, including a value finance leadership group, which meets fortnightly, made up of the Finance Delivery Unit, the Welsh government and health board finance directors.

Similarly, the national VBHC team has developed a network of implementation leads, and system oversight is supported by a group of executive leads led by a health board chief executive. As a result, these networks are developing to ensure all activity across Wales that involves evidence-based high-value interventions is collected and captured to support spread across the system.

Key partners

Mr Jones says NHS Wales partners with several bodies at national and local level to support implementation. The approach being implemented allows a focus on outputs, with a view to ensuring data can be shared in a consistent manner.

'From an outcomes perspective, we are focusing increasingly on capturing PROMs in a consistent manner, with consistent standards, irrespective of what the data infrastructure used to capture that is,' he says.

'We are merging different products across the system to do this on an all-Wales basis. We have a PROM standard operating model developed by the national team and this is supporting progress with this agenda.'

Mr Jones adds: 'Having existing systems enables the capture of the information, but we will also be able to consider different outputs in a single reporting repository.'

A good example of how data from multiple datasets has been integrated to support this agenda is the Finance Delivery Unit's development of the *Diabetes insight and variation atlas*. 'We pulled together all the existing data into an easy-to-use product for the system,' says Claire Green, deputy director of finance at the Finance Delivery Unit.

Value journey

The NHS Wales value-based prudent healthcare policy was launched in 2014 and five years later it published its national value-based healthcare (VBHC) action plan, which is the basis for its current work.

In the intervening years, there had been a focus on collecting and standardising outcome measures at Aneurin Bevan University Health Board. In 2015, the health board formed a strategic partnership with ICHOM, a global body that has developed a set of definitions for the outcome measures most important to patients. Initially, they focused on Parkinson's disease, and an all-Wales strategic partnership was formed with ICHOM in 2017, looking at implementing heart failure and lung cancer outcome datasets.

Dashboards for lung cancer and heart failure were established in 2018, while a national clinical lead for VBHC was appointed and a national VBHC engagement plan was developed.

NHS Wales agreed a relationship with the OECD in 2019, as well as launching a national VBHC action plan and merging the national PROMs and VBHC programmes.

In 2021, the Welsh Value in Health Centre was established to continue to drive the value programme across the country's health services.

She also leads the development of the product, working with national clinical lead Julia Platts and the unit's head of financial analysis Kimberley Rowe.

Data from a number of areas has been integrated and the Finance Delivery Unit has also brought in clinical outcome data, population data and information on adverse outcomes in specific sub-specialty pathways.

'We want to address adverse clinical outcomes through prevention, and upstreaming higher-value intervention,' says Ms Green. 'We are beginning to make progress. We are identifying high-volume interventions that will have the greatest impact on patients as well as maximising our utilisation of resources. This will mean doing things upstream and not having all the resources where they have been traditionally utilised at the end of the pathway.

'We are building a fantastic data product that is useful for clinicians and the system. We now need to use real clinical outcomes to highlight areas of variation where we can commit to prevention activity on a national basis consistently.

'Or, where we know the standard of care, we should be delivering information for local health boards to make progress in implementation and improving outcomes.'

VBHC in NHS Wales has attracted considerable international interest, and the NHS Wales Value in Health programme is one of the global innovation hubs of the World Economic Forum (WEF) global coalition for value in healthcare. The WEF value in healthcare programme includes peer-to-peer network communities, one of which is finance, and lived patient experience.

Mr Jones says participating in the finance network is helping to shape VBHC in Wales. This network provides an excellent opportunity to share learning and experiences of implementation with a range of other stakeholders from different sectors and industries, across different healthcare systems.

"We believe that we're beginning to demonstrate results in a diverse range of clinical areas"
Sally Lewis, Wales Value in Health Centre

Steve Elliot, Welsh government health and social services group interim director of finance, says: 'A continued momentum in adopting value-based healthcare in Wales is a priority for the Welsh government and supports our commitment to achieving the vision and ambitions set out in *A Healthier Wales*, our plan for health and social care.

'It also contributes to the government's commitment to addressing the delays in planned care as a result of the pandemic and forms a critical component of our financial strategy to ensure that the allocation and use of NHS resources in Wales is driving improvements in health outcomes for our citizens.'

Operation green

A recent HFMA roundtable, supported by KARL STORZ, discussed how decarbonising the NHS supply chain could have a major impact on the way operating theatres contribute to global warming. Steve Brown reports

HFMA ROUND TABLE

The NHS has set itself challenging targets to have net zero carbon by 2040 for the emissions it controls directly, and by 2045 for the wider emissions it can influence. All parts of the NHS will need to examine their established ways of working and make wide-ranging changes to deliver these ambitious goals. Operating theatres – major users of resources and energy and big contributors to NHS waste – will be a critical area for transformation.

Opportunities to improve the environmental performance in the NHS supply chain, particularly operating theatres, were the focus of an HFMA roundtable in May. Supported by surgical endoscope and medical device manufacturer KARL STORZ Endoscopy (UK), the event brought together clinicians, finance leaders and procurement specialists to share current work and highlight opportunities for improvement.

The wide-ranging discussion highlighted lots of good practice in the NHS – for example, in reducing the use of environmentally damaging anaesthetic gases. But there is potential for much wider cross-fertilisation between organisations and systems.

Nicky Lloyd, chief finance officer of Royal Berkshire NHS Foundation Trust and the roundtable chair, said the challenge was to kick start activity to reduce the service's carbon footprint and help organisations just starting the journey. 'We need to have a dramatic impact on the pace at which the net zero agenda progresses within the NHS,' she said.

Procurement requirements should help push progress on improving sustainability. For example, the NHS has decided to adopt and extend the public policy note PPN 06/20 requiring NHS bodies to take account of net zero and social value when awarding contracts from April 2022. And from April 2023, building on the further PPN 06/21, any supplier to the NHS with a contract over £5m must have its own carbon reduction plan to achieve net zero (see the net zero supplier roadmap).

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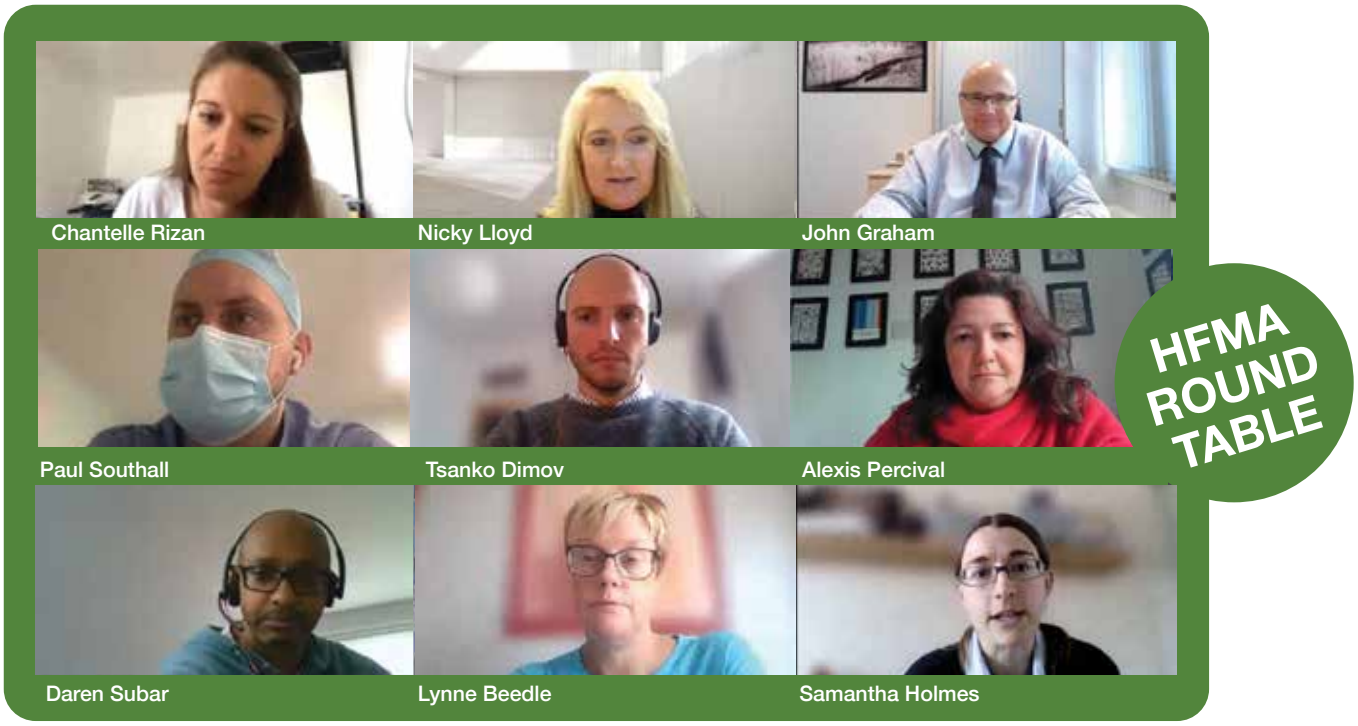
'The procurement standard for the supply chain will actually help to drive a lot of the sustainability requirements,' said Alexis Percival, environmental and sustainability manager at Yorkshire Ambulance Service NHS Trust and net zero lead for the Humber Coast and Vale Integrated Care System. 'The problem is I'm already seeing that the procurement and finance leads don't understand what needs to be asked or how to interpret the answer. So, lots of work needs to done working with supply chains.'

The focus increasingly had to be on sourcing sustainable products, she said. These may be more expensive in terms of upfront cost, but deliver savings in the long term because of their impact on waste reduction, reuse and whole life-time costs.

Supply chain accountability

Lynne Beedle, head of procurement at Rotherham, Doncaster and South Humber NHS Foundation Trust and procurement lead for sustainability at South Yorkshire ICS, agreed that suppliers had to be accountable for sustainability if the NHS was to meet its broader carbon footprint plus goal (the emissions it can influence). 'It's not just the direct supplier you are working with, it's their supply chain, and making sure that when you do a procurement, you dig into that,' she said.

Social value, which includes net zero progress and tackling economic inequality, must now be worth 10% of any tender evaluation under the new net zero and social value guidance. 'You have to not only ask them what they are doing at present, but what additionally they are going to do over the life of the contract to contribute to net zero and social value,' added Ms Beedle. 'And then you need to manage that through the whole life of the contract and make sure they are accountable on a six-monthly and 12-monthly basis for what they promised at the outset.'



Ms Lloyd questioned whether all organisations were fully aware of, and compliant with, the new requirements.

John Graham, deputy chief executive and director of finance at Stockport NHS Foundation Trust, said an enhanced focus on the environment should be clearly supported by boards and written into governance processes such as the scheme of reservation and delegation.

'There is a real opportunity for us at the moment to influence some of the decision-making principles at the integrated care system (ICS) level,' he said. There needs to be more consistency in organisations in putting together business cases with an emphasis on sustainability, he added.

Business cases

David Moon, strategic finance adviser for the foundation group that includes South Warwickshire NHS Foundation Trust and the Wye Valley and George Eliot Hospitals NHS trusts, said sustainability should be a clear mandatory consideration in business cases as well as in tender evaluations. The five-case model for business cases is supported by the Treasury's *Green book* and includes an economic dimension that should cover social value. But there is an argument for further emphasis.

'The NHS would benefit from really clear direction on the need to consider sustainability in business cases,' said Mr Moon. 'It should become custom and practice that you include the sustainability piece in any case you write.'

Mr Graham pointed out that, in recent approval processes for business cases at regional and national level, the Stockport trust was quizzed about the environmental impact. But he agreed this should be backed up by a formal requirement to address sustainability in business cases.

Tsanko Dimov, a senior net zero delivery manager at Greener NHS, within NHS England and NHS Improvement, stressed the opportunity of looking at full lifecycle costs in all procurement decisions.

'It can be difficult to demonstrate a saving,' he said. A product may appear more expensive in terms of the upfront price, but if you factor in a reduction in waste, for example, it can change the balance. The saving might be in a different department to the one making the purchase. Value, not cost, should be the goal.

There can also be other benefits too – for example, with personal protective equipment. 'One thing we see when we invest in reusable items, which can offer greater value over their lifetime, is that we can have better produced items,' he says. This could mean masks that fit a wider variety of face types better and so are more effective, enhancing staff safety while also improving sustainability.

'If we discuss the value that products are creating and how effectively they're doing their job, even if there is still an increase in cost over their lifetime, the value we might be getting may be much greater,' he said.

Chantelle Rizan said there was a growing body of research to support the lower environmental impact of reusable items using a lifecycle approach. Dr Rizan is in the final stages of a PhD at Brighton and Sussex Medical School and is a former sustainable surgery fellow at the Centre for Sustainable Healthcare. She echoed the importance of capturing the costs of single-use items incurred in different departments. 'There is also an issue with accurately predicting the number of users over a product's lifespan,' she said. 'Often business cases try to account for the cost over a short period, when in reality the product may last for 10 years or more.'

She suggested that procurement catalogues could be sectioned to highlight the choice of reusable or more sustainable items, where these offered the better value solution.

Participants

- Lynne Beedle, Rotherham Doncaster and South Humber NHS FT
- Tsanko Dimov, NHS England and NHS Improvement
- John Graham, Stockport NHS FT
- Samantha Holmes, South Warwickshire NHS FT
- Nicky Lloyd (chair), Royal Berkshire NHS FT
- Naomi MacKenzie, Wrightington, Wigan and Leigh Teaching Hospitals NHS FT
- Mark Martin and Ben Pinder, KARL STORZ Endoscopy (UK)
- David Moon, South Warwickshire, Wye Valley, George Eliot foundation group
- Alexis Percival, Yorkshire Ambulance Service NHS Trust
- Chantelle Rizan, Brighton and Sussex Medical School
- Paul Southall, Worcestershire Acute Hospitals NHS Trust
- Daren Subar, East Lancashire Hospitals NHS Trust

Daren Subar, a hepato-pancreatic-biliary service surgeon at East Lancashire Hospitals NHS Trust, said that more formal proof-of-concept would be helpful. 'If we could get 10 to 15 hospitals to explore sustainability programmes and monitor them over a period of time, that could be helpful,' he said.

Having evidence about the things that deliver results in practice could short circuit the decision-making process and galvanise a lot of trusts. This may not currently be happening on a national level – although best practice is shared via the Future NHS platform – but there are examples on a smaller scale within the West Midlands.

"We should have a sustainability checklist at the beginning of every operation to support a discussion about what equipment you are going to be using"
Naomi MacKenzie

Paul Southall is a consultant anaesthetist at Worcestershire Acute Hospitals NHS Trust and its lead for clinical sustainability. A local anaesthesia theatres network looks to establish best sustainable practice across the region and then roll-out what has been shown to work.

The trust was also one of five hospitals to pilot the social value procurement changes. 'We are trying to put in a minimum of 10%. For a couple of contracts, we've specifically stipulated a reduction in single-use plastics and packaging over a defined period,' he said. 'And that has to be auditable.'

Making an impact

His tip for engaging clinical and managerial colleagues is to convert kilogrammes of carbon dioxide to miles driven in a car. 'When you can say some of our anaesthetic gas capture will save five million miles in a car every year, it makes a big impact on people.'

Naomi MacKenzie, consultant colorectal surgeon at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, said infection control and sterile services teams were often barriers to change in theatres.

To counter this, Dr Southall said it was important to involve them at the outset. In Worcestershire, the aim is for the head of infection control to sit on the trust's sustainability working group. 'This won't mean objections disappear, but if you can get to them straight away, it's easier than trying to sort it when you've got everything 90% done,' he said.

Dr Rizan said that environmental accounting was the elephant in the room that needed to be addressed. 'A growing body of people want to support the transition to sustainable models of healthcare delivery,' she said. 'But we need to ensure they are delivering a true net benefit in terms of environmental impacts.'

She cautioned against relying on detailed and specific carbon footprint figures and impacts provided by industry, which often relied on different assumptions. 'I'd even be cautious about comparing figures derived by different research groups,' she said. Instead, she wondered if a simpler 'tick-box' approach could be taken to support decision-making, encouraging changes that would definitely have an impact on greenhouse gas emissions.

'I did a full lifecycle assessment of PPE used in the first six months of the Covid-19 pandemic, which equates to more than 100,000 tonnes of carbon dioxide equivalents,' she said. If this had been brought in by air rather than shipping, it would have increased the carbon footprint by 50% – and domestic manufacture would have provided a huge environmental benefit.

'Instead of relying on carbon footprints to make decisions, there may be some principles we can use instead,' she said. For example, trusts could ask suppliers about how much air freight is used in their supply chain. Eliminating use of air freight in NHS procurement would provide a major environmental dividend. She added that requiring suppliers to detail all the materials used in their products would help the NHS in identifying options for onward processing and recycling.

Dr Southall added that Worcestershire Acute was working with a local supplier and Loughborough University to analyse the trust's non-contaminated clinical waste to provide it with better information in this area. The aim is to explore the potential to develop a bespoke recycling service. While he said the ideal situation was to be provided with this information by suppliers, this two-pronged approach could give the trust a way to move forward with such a scheme more quickly.

Ms MacKenzie said steps could be taken in theatres to improve sustainability. These ranged from very small steps, such as wearing reusable hats, to addressing the use of greenhouse gases in anaesthesia and ensuring supplies are only opened when needed, rather than

Managed services: green benefits

Could the adoption of managed equipment services help deliver greater supply chain sustainability?

Under such deals, a supplier provides equipment as a service and takes responsibility for the maintenance, support, replacement and disposal of equipment that would otherwise be bought. Typical benefits claimed for the arrangements include reduced costs, risk transfer and operational efficiencies. But could they also have a green upside?

Research fellow Chantelle Rizan suggested that such deals may incentivise the manufacturer to design products that are durable and repairable. 'Then it is in their interest to really try to maximise the number of uses for that individual item,' she said. 'And that could be really powerful in terms of driving the transition to sustainable models of healthcare delivery.'

KARL STORZ Endoscopy (UK) sales and marketing director Mark Martin (pictured) said there were financial and operational benefits to a managed service and one of the ways it could help was in reducing the amount of travel associated with NHS services.

Around 3.5% of all road travel in England relates to the NHS, including patients, visitors, staff and suppliers.

'We already have onsite endoscopic support in some hospitals,' he said.

'This means that instead of 10 or 15 people coming into a hospital, we actually have somebody on site who works in the hospital – works in theatres, sterile services, outpatients, day surgery and medical engineering – and actually supports the hospital from the inside.

'That saves all the transportation,' Mr Martin added.'And using reusable surgical products can really improve things operationally and from an environmental aspect.'

opening everything in advance. 'We should have a sustainability checklist at the beginning of every operation to support a discussion about what equipment you are going to be using,' she said.

Some changes related to clinical practice and custom – the overuse of unnecessary surgical drapes, for example – and Ms MacKenzie stressed that reducing resource usage was always better than recycling. She also suggested that some open surgery procedures might be more environmentally friendly where they are clinically appropriate, enabling the use of more reusable instruments.

Ms MacKenzie also wondered whether surgeons were given too much flexibility and choice when specifying the equipment they needed. 'I think that culture within a department needs to stop,' she said. 'We should be told that this is the most sustainable piece of equipment.'

Others agreed with the aim, but underlined that clinicians needed to take the lead role in specifying equipment. However, procurement and finance managers should be empowered to challenge existing products and offer possible alternatives. For this to be achieved, clear board commitment to sustainability was vital. And Ms Lloyd said that this support needed to be visible, with organisations' green plans backed up with actions on the ground.

'It is so important to get board-level sign-up and to get sustainability written into the trust strategies and objectives,' said Samantha Holmes, finance manager at South Warwickshire NHS Foundation Trust. 'If you have environmental sustainability as one of the key targets for a trust, then that will naturally feed through into decision-making processes. But it absolutely needs to be top-down.'

HFMA ROUND TABLE

Board support was important, said Dr Southall, but it was a two-way street. In Worcestershire, progress had often involved 'punching up to the board', rather than responding to its demands. Environmental champions from numerous disciplines continue to play a major role in pushing the sustainability agenda.

Mr Subar said that the sustainability movement needed to be broader with a 'paradigm shift' needed in attitude. Until more people recognised that fixing the environment was an individual responsibility, he suggested some of the required changes would need to be mandated – such as the procurement of sustainable products. And given the urgency of the agenda, the NHS approach would need to involve more stick than carrot.

Cost of waste

There was certainly a danger that clinicians didn't appreciate the financial cost of waste, according to Ms MacKenzie. 'There is a problem in the NHS that consumables are seen as free – maybe we could learn from practice in the private sector,' she said, pointing out that most things were chargeable in the independent sector creating a different level of awareness.

Mr Dimov was concerned about forcing sustainability onto people and wondered if measurement and transparency could instead be used to encourage greater engagement.

'One thing that might be quite interesting would be to measure waste and use a leaderboard to celebrate and learn from surgical teams making meaningful reductions,' he said.

Dr Rizan said appealing to surgeons' competitive nature could help – the Centre for Sustainable Healthcare's green surgery challenge had been very successful. But she warned against too big a focus on waste.

'Waste isn't the problem,' she said, 'as it is less than 5% of the carbon footprint of the whole of the NHS. Even if we recycle to the maximum, we won't get anywhere near our target of meeting net zero. The real value of recycling will be when we start to increase the recycled content within healthcare products.'

Measuring waste was useful as a proxy for the quantity of consumables being used – with the real issue being the carbon associated with the raw material extraction, product manufacture and distribution. However, she said that further metrics, covering and going beyond waste, would be useful if they could be collected by all hospitals.

Roundtable attendees also pointed at more tangential ways to reduce the contribution operating theatres make to global warming. 'It is a bit more of a nebulous connection than reducing consumables,' said Ms Holmes. 'But with theatres being such a resource-intensive area, getting the maximum efficiency and productivity from your theatres means you are getting the most out of your equipment, estate and staff – and that has an environmental impact.'

Mrs Percival said avoiding the need for surgery could have the biggest environmental impact of all. 'We always concentrate on acute trusts, but in reality a lot of our carbon footprint is in primary care,' she said.

Primary care has not been required to produce green plans, she said, and there was limited support for general practice and dental surgeries on environmental issues. However, an increase in green social prescribing and more of a focus on prevention could have environmental benefits for hospitals in lowering activity as well as being better for patients.

'Models of care are really fundamental to changing everything in the whole of the system,' she said. 'And a lot of it is about de-prescribing and re-educating people. There is a lot we can do to eliminate interventions all the way through the system.'

Ms Lloyd said she was encouraged by the range and extent of work under way in many of the attendees' organisations. And she said there was a pressing need to expand the circle of environmental champions and to improve communication and the spreading of good practice organically across the whole of the NHS.

There were real opportunities to implement ideas that had already been shown to work elsewhere and so provided little risk for organisations.

However, she said that the finance community has a key role in measuring in monetary terms the environmental impact of decision-making and to ensure this was reported simply to those committing resources. 'And we all need to move at pace, right now,' she added.

Green inspiration

- De-steaming hospitals (Royal Berkshire) has saved millions of litres of water and 800 tonnes of carbon a year.
- Uniform recycling (Royal Berkshire) – staff returning unused uniforms that no longer fit has put 600 uniforms back into circulation.
- Convert all carbon reduction figures to miles driven in a car.
- Work with anaesthetists to audit and reduce or eliminate desfluorane and nitrous oxide use.
- Share ideas and get inspiration from the Greener NHS knowledge hub and procurement transformation pages on the Future NHS workspace.
- Include infection control sterile services representatives on sustainability working group.
- Establish clinical consensus on the preferred use of sustainable or reusable equipment.
- Consider onsite oxygen generation – giving surety of supply and eliminating significant amounts of transportation.
- Sustainability awards to showcase best practice.
- Explore whole lifetime costs including waste reduction and reusability.

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NHS finance careers: make your career count

In the third in a series of CIPFA webinars, leading senior NHS finance professional Hardev Virdee and recently CIPFA-qualified NHS finance business partner Mohammed Panjwani discuss their career journeys, the support they've received from CIPFA, plus future challenges and ambitions

More now than ever, the role of a finance professional in the NHS can be challenging, demanding agility, flexibility, resilience and responsiveness to rapidly-changing circumstances. Over the past two years, the UK healthcare sector's response to the COVID-19 pandemic have demonstrated just how important its role is, along with those of many other specialisms within the NHS. But, alongside the challenges, this dynamic environment also offers the opportunity for a uniquely rewarding and fulfilling vocation for those aiming for a career in finance.

In this webinar, Hardev Virdee, Group Chief Finance Officer at Barts Health NHS Trust – one of the largest NHS provider organisations in the country with an annual income of about £2bn and a workforce of over 20,000 – talks to Mohammed Panjwani, in his first year as Finance Business Partner at Milton Keynes Hospital, about their career journeys via the NHS graduate training scheme (some 20-years apart), CIPFA support and opening pathways for the next generation of finance professionals

Hardev Virdee (HV): Why did you choose to work in the NHS? Was it something around public sector versus private sector that led you to that choice?

Mohammed Panjwani (MP): For me, it's the idea that I'm contributing to something for the greater benefit of society. I've worked in other organisations in the private sector, but I felt like I didn't really have the motivation there. But in my current role, I know that the decisions that I make will have an impact on patient care – I know that I'm making a contribution, and it's my responsibility to make sure that I'm doing it as best I can. Also when I was younger, I was a service user of the NHS, so there is an element of giving something back as well.

It's about making sure that we in the NHS are providing value for money, and also providing great patient care. And it's also to do with the staff in the NHS – they're so resilient and at all levels are very inspiring. Is that the same for you Hardev?

(HV): Yes. I think that affinity is based on a set of underlying values. When I was given the opportunity to be on the NHS graduate training scheme, I was working in banking, and I had an attractive offer from a large bank. But what it came down to was which values I was most aligned to, and where I thought I could add most. It was based on my values judgment – it reflected me more as a person, and that probably helped shape my decision. It was also the value of public service that drew me more towards the NHS. So it seems that's a common factor for us.

So how did CIPFA help shape your finance training, your outlook on the opportunities that lie ahead for you and your development?

(MP): Because CIPFA is tailor made to the public sector, it provided me with the tools to develop and it was nicely integrated alongside the roles that I was doing within the NHS graduate training scheme – the competencies that I had to achieve as part of the graduate scheme fitted seamlessly alongside what CIPFA required for me to become qualified. I was able to use what I was studying in the CIPFA modules in my work.

Also, as CIPFA covers many other public sector bodies it was a great networking opportunity to talk to people who come from different organisations. Although it was my ambition to work in the NHS, I'm also interested in the public sector as a whole – anywhere I can feel like I can make a difference. And it's also great to have regular communications coming from CIPFA – it definitely helped me.

How about you Hardev? How does it look for you 20 years on from when you qualified?

(HV): CIPFA has evolved and developed, and it's much more progressive. CIPFA now is more relevant, and it's reaching out wider than just the public sector too. When I was studying, I was always told that CIPFA confined you to working in the public sector. But I have a lot more dealings with the private sector now than I have ever had.

I've been in private sector meetings many times, and they are astounded at the complexities of the NHS and how to navigate through the world of NHS finance. Through CIPFA you certainly have a broader range of skills that are applicable across all sectors. You also have a network with CIPFA that is supportive. I can see through CIPFA's leadership, through the way that the forums within CIPFA are set up, that it speaks to people coming through, and supports them through the career journey as well.

One of the reasons I contribute a lot more to CIPFA now is because I feel it listens and it's responsive, and it can support people like yourself and me in our careers as well.

And I think that support is really important. I've found that you need that support of people – whether that's mentors, coaches, a network or an individual – you need someone to lean on that can help you.

Do you have that support around you through mentoring and coaching or are you seeking to in fuutre?

(MP): I haven't really taken on or approached anyone to be a formal mentor or coach for, and that's just because I like to get a variety of opinions from everyone around me. I've got quite a few people within my organisation of the right calibre who I can go to for good, constructive feedback about how I've been working on a day-to-day basis, because I that's the only way that you can really grow.

In future, as I want to progress to more senior roles, I will try and approach someone about being a formal mentor or coach. Because I think that is something I'll need to get to the next stage of my career.

But how about yourself Hardev – did you ever have that support?

(HV): When I worked in and trained in West Midlands, I was lucky enough to have good people who helped push doors open. I found myself given opportunities at a very young age. At one point I think I was the youngest director finance in the NHS – and that that doesn't happen by chance. There are people who will help and support your career development, whether it's mentoring, coaching or support, and that is really important. Now I'm in the fortunate position to be able to mentor lots of people, and what I've tried to do in the NHS is put more structure behind this.

I've been working with CIPFA in a number of areas, particularly around workforce and equality, diversity and inclusion (EDI) too. I have a strong focus on people and on people development, and on equality. I'm chair of the National Finance Academy for the NHS in England, and we focus on providing recruitment, retention and development opportunities for all finance staff at every level to reflect the population we serve.

In the NHS Finance Academy, under the banner of One NHS Finance, we have a sponsorship programme. Sponsorship is about having someone who carries the flag for you, who will champion you as a person. They will do more than push that door slightly ajar – they will burst it open for you and give you those opportunities. That is a really positive step forward for us in the NHS, because not everyone is lucky enough to have the voice to get what they're looking for, in terms of mentors, coaches and opportunities.

This is about creating the future leaders based on the populations we serve and allowing that talent to really rise to the top – so that's what we're focused on. And it needs people like you. Mohammed, to play a part in creating that finance community that we all want.

Career opportunities

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

Hardev Virdee has been the Group Chief Finance Officer for Barts Health NHS Trust in London since November 2019, following a successful spell as CFO at Central and North West London NHS Foundation Trust. His career in the NHS began over 20 years when he joined their graduate finance training scheme in 1996 and gained his first board role as Finance Director in 2009.

Mohammed Panjwani is a Finance Business Partner at Milton Keynes University Hospital.

A finance professional with over 5 years of experience within the NHS supporting various finance functions.

He was a part of the NHS Graduate Management Training Scheme (Finance) where he undertook the CIPFA qualification and passed his final exam in June 2021.

Working in harmony

As integrated care boards prepare for new system leadership duties, freshly appointed board finance directors talk about their role as system conductors, the challenges and the opportunities ahead. Steve Brown reports

New integrated care boards begin life next month facing an enormous agenda. Arguably top of the to-do list is co-ordinating a system response to the very real pressures posed by rising waiting lists and a daunting recovery programme. But they are also charged with driving better integration of services within health and between health and social care, while switching the focus to the health of whole populations and addressing health inequalities.

This needs to be done within extremely tight financial budgets and with significant workforce pressures. Enter the newly appointed ICB finance directors, who will play major roles in helping their systems to meet these challenges.

The system approach will see a complex structure put in place, with a range of new bodies and partnerships that is likely to be quite perplexing to the general public.

The new ICBs will sit alongside system-wide integrated care partnerships, place-based partnerships and provider collaboratives. So what is the specific role of the ICB in delivering this joined-up approach?

Claire Wilson has moved from Wirral University Teaching Hospital NHS Foundation Trust, where she was chief finance officer, to become the director of finance designate for the Cheshire and Merseyside Integrated Care Board. The board is one of the biggest ICBs in England by population and budget and covers a wide geographic area that includes the city of Liverpool as well as the more rural Cheshire.

'It's about facilitation and enabling,' she says. 'It is about creating the framework and conditions that the system needs to succeed on the triple aim of health outcomes, quality of services and financial sustainability.

'That might mean setting the financial framework or financial incentives so that partners are enabled to do the best for the population,' she continues. 'Or it might be aligning our business intelligence functions across the whole system so that we are making really good, evidence-based decisions.'

Fundamentally, she says, it is about supporting a collaborative approach to the system's challenges.

A different approach

Speaking to ICB finance directors generally, there is a conspicuous absence of the word 'commissioning'. ICBs will take on CCG functions and the core of commissioning will remain – understanding the needs of local populations and co-ordinating services to meet those needs. But there is a determination to leave behind both the language and the mechanisms associated with the former internal market. The approach will be different.

West Yorkshire Integrated Care Board, for example – another sizeable system – has already blurred the boundaries between commissioning and provision in the run-up to the formal system launch in July.

'We increasingly rely on our provider collaboratives,' says finance director designate Jonathan Webb, former chief finance officer of Wakefield Clinical Commissioning Group.

'Sometimes this involves CCG staff working alongside providers or having outposted staff and we benefit from having different voices in the system. We co-produce the commissioning strategy. It is not just CCG people coming up with a specification. We've moved away from that to a great extent.'

It is about generating consensus on what needs to be delivered and how best to do that. And the ICB role is to bring people together and co-ordinate a combined response. 'We talk about having a system convener role,' he says. 'That language has been really useful as an informal partnership and I'm really keen to ensure we don't break what works.'

The complete commitment to partnership working and consensus is clear in West Yorkshire when you look at the make-up of its ICB board. Its six ICB executive directors are joined by five non-executives (including

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the chair) as well as representatives from the system's five local places and a local authority member. There are also representatives from acute, mental health and community providers, primary medical services and the voluntary sector, a director of public health and HealthWatch.

That amounts to 24 members in total and Mr Webb accepts it is not a typical board. 'But every partner is around the table and this runs through our West Yorkshire committees and our five place committees, which mirror the membership structure we have at the West Yorkshire level,' he says.

Decision-making in the run-up to the creation of the formal board has been on a consensus basis, including on how funds are distributed, and Mr Webb wants this to continue. Over time, the system may decide certain services are best co-ordinated and funded at a system level. But on day one of the new structure, '99% of the system's allocation will be devolved to its five places'.

It will then be for places to decide how resources are split between acute, mental health and community services and how money will be spent within each programme.

'We've revisited the needs-based formula at place level using NHS England data,' he says. 'However, we haven't followed this to the letter as that would have involved some fairly big movements of money and this year wasn't the year to do that. But we've incorporated the notion of a target place allocation into the way we are distributing money.'

Mr Webb says that initially, the amount of money being moved around is minimal – with changes capped at 0.25% of the allocation. But he insists this was an important signal.

'If we are serious about population health management and health inequalities, we need to take account of what the Advisory Committee on Resource Allocation says is the right amount of money relatively to be spent in each place,' he says.

"It's about creating the conditions to succeed on the triple aim of health outcomes, quality of services and financial sustainability"

Claire Wilson, Cheshire and Merseyside ICB

Risk sharing

Mr Webb adds that the system had already moved away from the old commissioner-provider relationships by dropping payment by results two years prior to the pandemic and before the temporary financial regime was brought in for the whole service. Its system of aligned incentive contracts has encouraged a sharing of risk across the system.

And while the approach shares similarities with the new national aligned payment and incentive approach, the national system's use of a marginal rate as part of its elective recovery programme is viewed locally as a backward step. 'We will have to look at how we manage the risk around this in 2022/23,' he says.

At Cheshire and Merseyside, Ms Wilson also says that this year, in which clinical commissioning groups have been leading the planning process, is a transitional year.

It will also be allocating down to its nine places while it moves quickly to develop a resource allocation strategy that considers how it can allocate funds to drive the required improvements in health inequalities and maximise outcomes.

'The contracts we are putting in place for 2022/23 will recognise an element of stability

The system finance team

As of July, CCG finance staff below board-level will all transfer to ICBs with an employment guarantee. In West Yorkshire, 80 finance staff and 35 contracting staff will move across to the ICB, while in Cheshire and Merseyside, Claire Wilson will be joined by some 120 finance staff.

Both point to the flat-cash management costs cap and the fact that the ICB will need to deliver efficiencies alongside the rest of the system. However, with significant financial responsibilities and tasks across place and at system level, both anticipate these numbers broadly continuing to be needed.

In Cheshire and Merseyside, the plan is to agree an operating model for the finance processes and then design the structures to support this. 'That detailed work can only happen legislatively from 2 July onwards,' says Ms Wilson.

'We will take a staged approach to how we form as a finance team,' says Mr Webb. Four functions will be required on a West Yorkshire footprint. A financial accounting and financial services function, the members of which were identified in advance, will be joined by a system financial management function for an all-system view. A corporate financial management team will look after board and finance committee reports. And a financial strategy function will work alongside places.

While initially, existing structures will stay in place, some changes will need to be swift – Mr Webb has a first investment and performance committee planned for August, which means a team must be up and running.

Former CCG chief finance officers will move across as finance leads in the majority of the system's five places.

In Wakefield, where Mr Webb was previously CCG chief finance officer, the system will try a different model for the place-level finance lead. Here, the place finance lead role was included in the job specification for the Mid Yorkshire Hospitals NHS Trust's new chief finance officer..

There may well be opportunities to collaborate more widely as a system on financial activities, but Ms Wilson says this would be for the whole system to discuss.

While Cheshire and Merseyside's five-year plan spells out the intention to look for opportunities for collaboration on corporate functions at scale, this doesn't necessarily mean a shared services approach. Instead, it might mean exploring the potential to establish a single ledger, which would make reporting more straightforward, or to collaborate on costing. And it might mean building on existing procurement work to explore the potential to take further advantage of the system's scale.

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is needed,' she says. 'But we also want to move to something closer in line with the aligned incentive contract principles, which will enable us to move resources around the system to support elective recovery. So, if an organisation is unable to deliver on its elective programme for whatever reason, we've got a facility to enable mutual aid and support investment in capacity somewhere else.'

She says system partners, including the provider collaboratives, are working to develop the future operating model. 'This will help us define what is delegated and determined at place and which services are planned and delivered at scale,' she says.

Over time, some resource could be allocated at system level – although this is likely to be very small at first. 'You might consider an elective recovery programme managed at scale, with provider collaboratives working as the delivery vehicles, rather than routing the money through place,' she says.

She suggests the initial 'hybrid' approach will give the system stability and flexibility in its first year. However, the system – in fact the whole country – faces significant financial challenges.

'All organisations have to deliver 1.1% as a minimum – that's basically baked into the allocation [and national tariff guidance] as an implied efficiency,' says Ms Wilson. 'Cheshire and Merseyside then has to deliver 0.9% over that because of our convergence factor.'

This factor is being used to reduce overall NHS resource consumption to spending review 2021-funded levels and it is higher for Cheshire and Merseyside than the England average of 0.6% because of the system's relative overfunding compared with its target allocation.

So, within the system, all organisations are having to deliver 2% as a bare minimum, while also covering any local pressures. On top of this, Covid funding has reduced by around 60% compared with last year's levels and organisations are required to review infection prevention and control measures in line with new clinical guidance to respond to this. It is a huge efficiency ask at a time when services are also being urged to go the extra mile on elective recovery. Given staff vacancies and

"It's not just CCG people coming up with a specification. We've moved away from that to a great extent"

Jonathan Webb, West Yorkshire ICB

Getting going

Excited to get going. That is how Sam Proffitt (pictured), finance director designate of the Lancashire and South Cumbria Integrated Care Board, describes her feelings about the formal move to system working in July.

In reality, the system has been working towards this formal restructuring for years and Ms Proffitt, its director of provider sustainability, has been at the heart of that. But she is keen to see what can be delivered with the new arrangements once the new structures are established.

'There is a here-and-now pressure with everything happening at once,' she says. For her system, that means merging eight CCGs into the new board, creating board structures and getting the new executive team up and running. 'But that will pave the way for something that is going to be really exciting,' she says.

She believes the system has advantages – including a sensible number of organisations (four acute and a single community and mental health provider within the NHS) working across the patch with established collaborative working. 'And we've got the data that shows us where we can go to try to improve the financial position,' she says. 'All of that is really positive.'

The system is assessed as being 6.5% over its target funding position in the current year, which could mean reduced growth relative to other systems in coming years as the whole country moves towards fair shares on allocation.

'But we can't look at that in isolation,' she says. 'We've got to think about how we are performing now. Yes, we are above target and we've got some significant challenges, including numbers of Covid patients that have exceeded the levels assumed in national planning guidance. But we've also got a lot of duplication and waste in the system.' This includes having five trusts with similar infrastructure and back office arrangements. RightCare and Model Hospital data also show significant variation and potential inefficiency across the system's clinical networks. Ms Proffitt says the provider collaborative will have a key role in addressing this.

'We absolutely should be looking at a single clinical vision, a single workforce approach and being organisationally agnostic when it comes to our population's needs,' she says. 'So it is not just about how we find more money to invest, but about putting resources in the right places and taking some of the waste and inefficiency out of the system.'

Addressing health inequalities will be a key priority, with major variation across a patch that includes Blackpool, the most deprived local authority area in England, and more affluent areas of West Lancashire. 'Listening to the right voices and hearing the right messages will be essential,' she says.

However, Ms Proffitt believes the service and efficiency improvements can't all be done overnight. It will require a five-year plan and longer-term financial strategy.

The challenge will be to design a financial framework that supports the system and provides the right incentives to drive collaboration and support people out of hospital.

With 2022/23 seen as a transition year, the system is also looking to develop allocation mechanisms for the future that move resources to place. Clinicians are already involved in this work and the ICB is appointing a place finance director as part of its central structure to support this agenda.

absences, this may mean additional spending on waiting list initiatives, overtime and more expensive temporary staffing.

And with the system assessed as being some £300m over target allocation, it could face years of minimal growth as it moves to its fair share of funding.

Achieving ambitions

Given the tough financial context, how can systems make good on their ambitions to transform services, increase community provision and move towards prevention and addressing the wider determinants of health?

'That is the big challenge,' admits Ms Wilson. 'We have to deliver on today and the particularly difficult financial situation we're facing. And at the same time, we have to find ways to do the redesign and transformation work that will make the position more sustainable and deliver the impact that systems are set up to have, especially embracing its population health and health inequalities remit. The reality is there isn't an either/or; we've got to do both.'

The opportunities will come from a collective strength and bringing all the system partners together to tackle the issues. In some ways, the challenge has always been the same for the NHS, but Ms Wilson is optimistic that the new collaborative approach will bring down some of the barriers that have hindered progress in the past.

In West Yorkshire, Mr Webb says it is all about giving signals and highlighting the small successes. 'Last year we collectively constructed a £12m package for social care to bring forward the national living wage early to 1 December (from 1 April),' he says. 'This was seen as a really good thing to try to protect against attrition of staff across winter and losing them to better paid jobs in retail. We also put £1m into a voluntary sector warmer homes initiative.

'Also, to show that population health matters, we have ringfenced the very limited £11m funding we've had this year for health inequalities and we are deploying that on the core20plus5 priorities.'

Ensuring this money is not just used to improve the bottom line is a further signal of the system's intent to make progress even amid such pressures. But it is not just spending the money in a particular pot, he insists, but what is done with the money once allocated.

He cites recent work on health inequalities in waiting lists at Calderdale and Huddersfield NHS Foundation Trust (*Healthcare Finance, March issue, page 10*). This did not involve extra funding for the trust, but changing processes locally within existing funding levels to address inequalities in access to care.

Ms Wilson says the trick is working together for a common goal. There is an element of the ICB having a formal role in the system hierarchy – but only in terms of arrangements for accountability and governance.

Its system leadership role is more about facilitating a collaborative response to issues that need it. It is not a replacement regulator for NHS England and NHS Improvement, although interaction may increasingly be delivered through the board.

'People in the system may talk about the ICS telling them to do something,' says Mr Webb. 'But that misses the point. We are all the ICS. The ICS is no more than the combination of everyone round the table.'

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Tuning in to priorities

Matt Gaunt, director of finance designate for the Lincolnshire Integrated Care Board, talks to Steve Brown about some of the priorities facing the new system

On first look, Lincolnshire Integrated Care Board appears to be one of the more straightforward systems formally launching in July. It takes on the functions of a single clinical commissioning group and is coterminous with the county council, which also neatly fits with the boundaries of the seven district councils. It includes just three trusts – one acute, one community and one mental health provider – all with Lincolnshire in their titles. And it will operate as one single place.

But beneath the surface, Lincolnshire faces many of the same challenges as the rest of the country – but also some issues specific to its own system.

'There are a lot of complicating factors and challenges quite specific to Lincolnshire,' says Matt Gaunt, director of finance designate for the ICB and chief finance officer of the preceding Lincolnshire CCG.

These challenges include a rural county with 50-mile strip along the east coast that has a significant amount of deprivation and is poorly served by infrastructure, public facilities and even mobile phone coverage. With some richer rural areas too, addressing health inequalities is high on the agenda.

Workforce challenges

Workforce is the other standout issue. The recently established Lincoln Medical School at the University of Lincoln only took in its first students in 2019, with the specific aim of improving the recruitment and retention of doctors to Lincolnshire.

But the lack of such a facility up to this point has contributed to an underlying vacancy rate that is around a third bigger than some other systems and high temporary staff costs. 'We spend more than double our agency cap,' says Mr Gaunt, 'and we are massively reliant on bank and agency.'

Partly as a result of both the inequalities and workforce issues, the system experiences high use of urgent and emergency care services – with up to 40% of the adult population in some coastal communities living with a life-limiting condition or disability – and the higher costs that come with that.

The county also has dispersed facilities, with acute medical services located in three places, which again create difficulties given the relatively small size of the population for the area covered. 'So we have three really big issues – inequality, workforce and infrastructure,' he says. 'And that is driving a lot of my thinking about priorities.'

Difficult to address at the best of times, these issues become harder in the current financial climate. Mr Gaunt says the first task last year was to frame the financial challenge in a way that seemed manageable – separating out those things that could be addressed in the short term and those that would require a slower burn.

Mr Gaunt estimates the system had an underlying deficit of around £100m as it entered the pandemic – about 7% of its £1.5bn allocation. About half of this is tied to longer term issues such as rurality and infrastructure. The other half splits between things that can be tackled by individual providers driving efficiency and those things that require improved service integration through a system response.

For providers, there are a range of operational issues. 'There are high costs related to the way we operate and the efficiency within our services,' he says. This is about addressing variation, with clinicians assessing risk, agreeing standards and the clinical thresholds for interventions, and then adhering to them. This is as much a cultural exercise as a technical one, Mr Gaunt adds.

Then there are system opportunities, where pathways across multiple organisations and teams are optimised for the benefit of patients and to eliminate duplication and cost. Or it could involve delivering earlier interventions to avoid people joining the pathway altogether.

Mr Gaunt insists the system is not ignoring its responsibility for the longer term structural issues that need to be resolved. 'But we are trying to tackle what we can do here and now and breaking the response into manageable chunks,' he says.

Even so, the challenge is significant given a very tight financial year, with convergence adjustments reducing allocations, major reductions in Covid funding and inflation already exceeding the levels assumed within the spending review settlement.

Mr Gaunt says funding will need to be used to address inequality. But this will involve targeting growth at key areas rather than cutting budgets in one area to expand them in others. 'It's the difference between a pilot and a rollout,' he says. 'We will always pilot change in areas with the greatest need, because, if we can land it in those places, then we will have the best chance of having an impact.'

Analytics will be vital for targeting interventions in the right place and population health management, for which Mr Gaunt is responsible, will be a key tool.

'I need to do a lot of thinking about how we build analytical capability,' he says.

'Historically, most of our analytics time has been spent on contract management; we need to tip it away from that into more insights about the interventions we can make. We need actionable analytics that let us get under the skin of urgent emergency care usage, for instance, and get to the root cause.'

"Three really big issues – inequality, workforce and infrastructure – are driving my thinking about priorities"

Matt Gaunt

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Wearable wins

The NHS is keen to realise the benefits of developments in medical technology, such as wearable sensors, which can facilitate more out-of-hospital care. Seamus Ward reports in the latest of our series supporting the HFMA programme on driving up value and efficiency through digital transformation

Time and again it is said that patients and NHS services benefited from the rapid adoption of digital technology during the Covid pandemic. Video links allowed patients to consult with their GP without either party risking catching the virus. Wearable sensors, measuring vital signs such as blood oxygen levels, heartbeat and blood pressure, helped move patients out of hospital, freeing up beds and reducing infection risk.

These experiences pointed to a future in which inpatient beds are reserved for the sickest, while those with chronic disease live in their own homes or care homes when not in the acute phase of their illnesses.

Most consumers interested in health will be aware of the rapid development of digital watches that can track heartbeat, distances run or walked, even blood oxygenation. While most of these are not medical grade devices, there have been advances in clinical medical technology, or med tech, with new and smaller wearables freeing up patients to move around without being tethered to bedside monitors.

In this new world, the NHS must be fleet of foot, adopting the technology required to support patient and staff needs. Finance staff will play an important role – supported by the HFMA's *Delivering value with digital technologies* programme.

The programme, which is supported by Health Education England, aims to increase awareness of digital healthcare technologies among NHS finance staff, while enabling finance to take an active role in supporting the use of digital technology to transform services and to drive value and efficiency.

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The adoption of new technologies is not straightforward. There is opposition from patients who may not have access to the internet, or are less comfortable with technology.

Some sections of the media want clinicians, particularly GPs, to offer more in-person consultations, rather than by video link. And, with insufficient evidence collected, there are questions over whether digital is a more efficient use of resources.

Work remains to be done to ensure the changes have an impact on underlying issues identified before the pandemic, says Nuffield Trust fellow Rachel Hutchings. She has researched digital adoption in the NHS, including a report last year on practical steps for implementing digital innovations.

Training of clinical and non-clinical staff is vital, she says. 'We found in our work that when implementing digital technology, it's not just a case of putting it in and expecting it to work. Training is really important. And there are underlying issues, such as variation in the adoption of digital technologies across health and social care. There are still deficiencies in digital maturity in NHS organisations.'

"It's not just a case of putting digital technology in and expecting it to work. Training is really important"
Rachel Hutchings, Nuffield Trust

She adds that integrated care systems will be taking a greater role in managing and developing digital across their areas, providing an opportunity to address digital needs.

'We can see there's huge potential and opportunities in med tech for improving the experiences of patients and staff, and in the running of the wider healthcare system. For example, during the pandemic, patients saw a lot of the potential for increased access through remote monitoring, improved options for self-management of long-term conditions, or through providing an alternative for greater choice.'

Ms Hutchings adds that there were also benefits in social care, with staff and clients seeing the potential to use data more effectively and provide more joined-up care.

In-person options

Despite the enthusiasm in the health service for the possible gains to be made, she insists face-to-face consultations must remain open for those who don't want to – or cannot – access digitally based services.

In developing digital tech, the health service must take care to be guided by real needs, rather than just opting for the latest gadgets. 'We identified in our work that there had to be support to implement different types of medical tech. There must be co-design, working with users, patients and staff to understand what they need and make sure the technology is appropriate for the population,' Ms Hutchings says.

As well as matching an organisation's digital maturity, new tech must match local people, she argues. There is no point in replacing face-to-face appointments with a digital monitor if the cohort of patients are not willing to use it or are unlikely to feel reassured by it.

Nevertheless, many in the NHS and the government, as well as NHS England and NHS Improvement, believe the rapid adoption of technology during the pandemic has shown the way for the next stage of the service's development.

A lot of excitement surrounds the use of technology to facilitate virtual wards. These are 'wards' of patients often with similar disease types living at home. Their health can be monitored using wearable devices, which can report directly to the provider's clinicians or with the patient inputting their data via a tablet. This is supplemented by video and phone calls.

While virtual wards can be facilitated by technology, they do not always need a digital element, Ms Hutchings insists. 'For most people with long-term conditions, it's about how technology can support them and enable greater access. It's not necessarily a replacement, but to complement and enable healthcare. Technology is not an end in itself.'

NHS England and NHS Improvement have requested that integrated care systems (ICSs) work with providers to develop and expand the use of virtual wards over the next two years. ICSs have been asked to ensure that there are 40 to 50 virtual wards per 100,000 population by December 2023.

The national bodies have provided £200m in 2022/23 to support this, with £250m on a match-fund basis in 2023/24. ICSs will be expected to fully fund their virtual wards from 2024/25.

Norwich virtual ward

Norfolk and Norwich University Hospitals NHS Foundation Trust has established a 24/7 virtual ward to support patients who would ordinarily require an acute inpatient bed to continue their recovery in their own home, or monitor their condition in the run-up to an operation.

The virtual ward has the capacity for up to 40 patients who can be transferred from inpatient wards, direct from clinic and from the emergency department. Virtual ward rounds and phone or video calls via a provided tablet are made daily. Patients wear a sensor that monitors skin temperature, pulse, and oxygen saturation levels remotely, with the information recorded in the clinical dashboard. Blood pressure can also be taken when required.

Patients can contact clinicians directly by pushing a button on the screen should they have any concerns between the ward rounds. The virtual ward patient kit includes a modem to provide internet access, overcoming concerns that virtual ward programmes could exclude some patients without an internet connection.

Patient feedback has been overwhelmingly positive about the service, which has seen more than 1,100 patients to date since implementation in February 2021, releasing more than 7,700 inpatient bed days.

Emily Wells, chief nursing information officer, says: 'We're making great strides in modernising our services across Norfolk and Waveney and embracing digital services with the advantages they bring to patients and colleagues. Even though we started behind other health systems in terms of digital maturity, our virtual ward is performing exceptionally well with fantastic patient feedback.'

Virtual ward manager Claire Beard adds: 'The feedback has been overwhelmingly positive. Patients being able to be in their own bed makes such a huge difference and aids their recoveries.'

Patients with irregular heartbeats normally spend two or more days in hospital being closely monitored to assess how they react to treatment. But thanks to a new virtual ward, up to 120 University Hospitals of Leicester NHS Trust patients with atrial fibrillation (AF) can remain at home during the close monitoring phase. AF, which affects 1%-2% of

the general population and 10% of those over 70, is associated with an increased risk of stroke compared with those with a normal heartbeat.

In a pilot, patients were given equipment to monitor their blood pressure, heart rate and oxygen levels, and a device to produce an electrocardiogram (ECG), which assesses heart rhythm. An app sends the data to virtual ward clinicians.

The full service has now been launched with £274,000 of funding from the NHS England transformation directorate (formerly NHSX) in association with tech specialist Dignio.

Future of care

Andre Ng, consultant cardiologist and electrophysiologist at the trust, says: 'This is a glimpse into the future of care for patients with atrial fibrillation. This service allows patients to be managed and recuperate in their own homes whilst their heart rhythm settles back to normal, but with the peace of mind that they're still being monitored by specialists.

'We have already received great feedback from the patients treated, and have successfully managed patients with reduced hospital stay and avoided admission or readmissions.'

Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH) is using similar remote monitoring to help patients with arrhythmia, including AF, stay at home during the initial observation phase. Patients wear a compact showerproof device for up to 14 days, which collects data on the heart rhythm. The device is then posted to LHCH's partner, iRhythm, for fast analysis using artificial intelligence.

'We believe this has significantly improved patient outcomes across the trust, as patients with undiagnosed and unmanaged heart rhythm conditions are much more likely to have recurrent symptoms such as blackouts or palpitations and some may even progress to a stroke,' says consultant cardiologist Jay Wright. 'We see this service as a fantastic new tool in our efforts to prevent this.'

Waiting times for ECGs fell from six weeks to a matter of days during a pilot of the technology. By avoiding the pinch points in the traditional methods of diagnosis, which may involve overnight stays in hospital and repeat testing, the scheme has freed up beds and other resources.

The trusts implementing medical technology emphasise the benefits to patients, yet there are also potential savings, such as reduced bed days and the avoidance of costly, often invasive, diagnostic procedures.

Nuffield Trust's Ms Hutchings says efficiency should be a byproduct of schemes that use technology to improve care to patients, repeating that the technology should not be an end in itself. 'You've got to be careful if you are seeing tech as a way of cost saving. It has to support your plans and not just save money. Technology also requires ongoing investment to make it sustainable – it is not a quick fix,' she says.

'How do you enable the right patient to be treated in the right place at the right time? How do you support people when they don't need to be in hospital? There's potential for cost savings, but the primary aim must be to treat patients appropriately.'

Digital medical technology has great potential in the NHS and the service is already using it to move or keep patients out of hospital, open up pathways or provide new treatment. However, the focus of the service must be on making changes that benefit patients and staff.

• For more on *Delivering value with digital technologies*, visit hfma.to/mof. The programme has also published case studies on remote monitoring at http://hfma.to/jun221

Clot preventer

A venous thromboembolism (VTE) or blood clot is a common and potentially fatal complication of acute stroke, occurring when patients have less mobility due to prolonged recovery or bed rest after a stroke. Blood flow to the legs is reduced, making clotting more likely.

However, a small wearable device, being used at the Royal Stoke University Hospital and others, is helping prevent VTE by increasing blood flow to the lower limbs and back to the heart.

The Geko device is being used as an alternative to more standard VTE prevention. The existing treatment – known as intermittent pneumatic compression (IPC) – uses a small plastic sleeve worn around the leg that is inflated periodically to squeeze the calf, which increases blood flow.

Indira Natarajan, consultant stroke physician and clinical director of neurosciences at the University Hospitals of North Midlands NHS Trust, says IPC is an effective method of VTE prevention. But 30% of patients are contraindicated

or unable to tolerate IPC due to medical conditions, such as fragile skin, or noise from the electric pump disrupting sleep. There was no alternative to IPC to prevent blood clots in these patients, he says.

The National Institute for Health and Care Excellence has supported the use of Geko for these patients. Professor Natarajan says the Geko device is small – about the size of a wristwatch – and worn at the knee. 'It gently stimulates the common peroneal nerve, resulting in increased blood flow in the deep veins of the calf, equal to 60% of walking, without a patient having to move. It is comfortable for patients to wear and simple for staff to administer.'

It could be used across the NHS to address post-stroke VTE prevention, he says. 'Real-world data from a review of 2,000 acute stroke patients at the Royal Stoke University Hospital reported the device is safe and well tolerated and led to a 46% reduction in VTE,' he adds.

'Nursing staff prefer Geko as it does not have to be connected and disconnected when patients get out of bed. It's also less likely to be soiled by incontinent patients.'

While Geko and IPC have similar costs, the former has been shown to deliver a cost saving to the healthcare system, he says. 'Six days' use of Geko in acute stroke is estimated to save the NHS £337 per patient, when no other VTE prevention can be prescribed.'

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A helping hand

Sometimes people – especially those in under-represented groups at the senior level of NHS finance – need a little help to make their next career move. Steve Brown explores the One NHS Finance sponsorship programme

When Rebecca Mae-Rose (pictured) joined Mid and South Essex NHS Foundation Trust in 2019 – her first job in NHS finance – she had no intention of staying. But the three-month temporary contract was enough time for her to catch the NHS bug and change her long-term employment plans. She was hooked, but how could she make up for lost time and ensure her career wasn't hindered by her late start?

Fortunately, help was at hand in the form of the One NHS Finance sponsorship programme, which aims to help high-potential finance staff by matching them with a senior finance leader. In particular, the programme is aimed at finance practitioners from groups that are under-represented at director level in NHS finance – women, individuals of black, Asian and minority ethnic background, those with disabilities and individuals who identify to the LGBTQ+ community.

Ms Mae-Rose had plenty of work experience. She had completed her advanced and professional level accounting qualifications with the Association of Accounting Technicians, while working in low-secure mental health hospitals and in the city. She had also spent 12 years working for herself.

Her temporary NHS position was as a band 5 management accountant, working on group accounts in the run-up to the merger of three trusts (Basildon and Thurrock, Mid-Essex and Southend) into the single foundation trust in April 2020. But she was subsequently offered a substantive role at band 7 supporting the trust's costing and benchmarking function.

"I was really keen to understand the nuts and bolts of how the NHS works – not just the things you learn on a course, but the way people connect"
Rebecca Mae-Rose

She signed up to study for her CIMA finals and believed that her skills developed from the private sector and self-employment – in business consultancy and events – would be a big benefit. This was particularly the case as the trust moved increasingly into the use of service line reporting and undertaking deep dives with clinical services.

She threw herself into development activities and getting involved with the wider finance function by becoming the co-lead for Future-Focused Finance within the local integrated care system. It was by exploring the opportunities available through FFF that she came across the sponsorship programme.

'I'd been aware from the beginning that I don't have the strongest NHS background and it is a massive organisation to understand,' she says. 'I was really keen to understand the nuts

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and bolts of how it works – not just the things you can learn on a course, but the way that people connect. That doesn't happen from just doing a course.

'It is better to be able to link in through another person and almost see the NHS world through their eyes, their experiences and learn that way. And I also wanted to understand how I could progress.'

Ms Mae-Rose highlights the added benefits of having a sponsor outside your own organisation. 'In your day job, you look solely at your role and your organisation all the time,' she says. 'But for me, the sponsorship was a bit of a chance to helicopter over your role, your career and really see the wider picture.'

Ms Mae-Rose didn't meet all the sponsorship programme's criteria – in particular, the requirement to have been in the NHS for three years. But given her FFF work and enthusiasm, she was accepted onto the scheme and matched with David Bacon.

Mr Bacon is an experienced finance director. He has held the lead finance role at Hertfordshire Community NHS Trust for nearly four years and brought to that position a background in both interim and substantive senior finance roles spanning more than 30 years. During that time, he has also been a regular member of the HFMA Accounting and Standards Committee, chairing the group for some 10 years.

He was keen to give something back to a function that has been good to him.

'I recognise that throughout my career I've had help and support from managers, the HFMA, systems and regional colleagues,' he says. 'And that has given me a large network of contacts. Part of the sponsorship programme is to share some of that knowledge and replicate the support I had in the past and provide it to the next generation.'

"I recognise that throughout my career I've had help and support from managers, the HFMA, systems and regional colleagues"
David Bacon

Some of the support mechanisms and networking opportunities that existed previously are not as strong as they used to be, says Mr Bacon – despite the added benefits of social media and greater use of technology for communication.

'Some of the ability to attend a meeting, to sit next to people, or to talk to someone over a coffee has disappeared – particularly over the last two years when we've all been working more from home.'

Flexible approach

The programme does not impose a fixed routine on the sponsor and sponsee – instead they are left to plan out their own interactions. In the case of Ms Mae-Rose and Mr Bacon, this translated into a half-hour Teams meeting once a fortnight.

'We've not really had an agenda,' says Ms Mae-Rose. 'It's more flowed with where I am at at that point. So there have been times when I needed advice on fitting studies around a busy family life and busy job. And we've taken quite a big look at my longer term NHS plan.'

One particularly useful tip she highlights was Mr Bacon's recommendation to use job specifications and adverts for director and deputy roles to identify experience gaps. She says this has helped her to think about how she could collect the right bits of experience that would help her to reach her career goals.

She points out that many of her colleagues who are at the same qualification stage are younger, while she brings different skillsets from previous jobs.

'So it is trying to make sure that I've got enough of the right mix coming through and that I'm using my time to gain the things I need,' she says.

One key message she has taken on board is that you should not always take the line of least resistance.

'David pointed out that, long term, if I've not done a good stint in financial accounts, that could hold me back,' she says. 'It can be really easy to go where it feels good and follow your natural skill path. But this may not always address your skill gaps.'

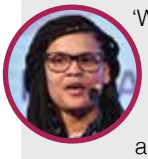
She adds that being able to talk frankly with someone outside your organisation, however good your relationship with your line manager, is a real asset.

Mr Bacon is clear that being a sponsor is different from a mentoring relationship – it involves using your influence to help somebody's career development.

That can mean providing opportunities or introductions, or on occasion advocating on the sponsee's behalf. In particular, this can involve helping to develop the sponsee's own network.

Ms Mae-Rose has shadowed Mr Bacon and attended some formal committee meetings at Hertfordshire. But some of it is simply about introducing her to people. They met in person for the first time at the HFMA annual

'Come and get us'



'We've got your future leaders, we've got your pipeline. We just need your support to get to where you are.'

That was the rallying cry from Natasha Munro (pictured), senior finance manager at NHS England and NHS Improvement, at the HFMA annual conference in December, as she called on the assembled senior finance leaders to make use of the talents of all parts of the finance family.

Ms Munro, who joined the sponsorship programme in 2018, was highlighting the expanding pool of sponsees from the national programme all getting themselves ready for that next step up. Some 199 sponsees (and 202 sponsors) are signed up to the programme, with a concentration in the North West (70) and London (47). The programme is open to staff at all bands. However, the matching process for staff at bands 8a upwards is handled by One NHS Finance's National Finance Academy (NFA), while those for band 7 and below will be arranged by regional academies. The NFA website will remain the first port of call for any new sign-ups to the programme.

The sponsorship programme is a deliberate response to address the fact that the senior tiers of NHS finance do not reflect the diversity of the NHS or its finance function as a whole. According to the 2019 finance function census, while women make up 62% of the NHS finance workforce, only 29% of finance directors are women. Two-thirds of all women are at band 6 and below, compared with 45% of men. And while 75% of NHS finance staff are white British, this rises to 92% at director level.

conference in December 2021 – with Ms Mae-Rose attending on the back of a scheme set-up by East of England regional director of finance Jeff Buggle to support the development of finance staff as part of the region's own inclusivity agenda.

'The HFMA conference was a really big thing for me and for my organisation to give me the time off to attend it,' she says. 'Having the time to network outside of the costing community with wider NHS finance staff was so valuable. Online meetings allow us to do so much in a time-efficient way. But face-to-face opportunities at the conference provide a different level of engagement.'

She was introduced to finance directors and other senior finance staff, including HFMA Finance Director of the Year Nicci Briggs.

Ms Mae-Rose is also grateful for the opportunities to attend some high-level meetings at Hertfordshire – especially given the trust's focus on community services. She says attending an audit committee meeting – and hearing the questions asked by non-executives – has helped put the overall finance role into context and underlined the importance of reports prepared for the board or other committees.

Ms Mae-Rose says the sponsorship programme has given her confidence and encouraged her to look up from her day job and think more widely.

'I have learnt things that enhance my day job, but I've also gained a wider understanding of why we do what we do – it has been massively valuable.'

Beyond the current sponsorship arrangement, she is planning to shadow roles within her own organisation at a more intermediate level to help address some of the gaps she has identified in her own experience.

Stepping up

In principle, the sponsorship should last about two years, with the idea being that the programme should help the sponsee to step up to their next role in that time.

Mr Bacon suggests that the programme has not changed Ms Mae-Rose's aspirations or ambitions. 'But I think it has given her more clarity about how to achieve them.'

He says he has also learnt from the experience. 'I think that it has helped me to understand a bit more some of the barriers to progression that some groups face,' he says.

'I probably thought I knew what some of the barriers were, but I didn't realise the existence or extent of all of them. So it has helped me to increase my awareness of what some people in the NHS as a whole are dealing with just to try to progress.'

He adds that this is helping him to work out what he might do for his own finance team. 'I am thinking about what I can do proactively to encourage people and not just assume that people will come forward when they want to do something.'

Ms Mae-Rose believes the sponsorship programme is a win-win-win: the sponsee gets the support needed to develop and progress their career; their employer gets an employee with enhanced skills to use in their current or a future role; and the finance function gets a larger pool to feed future senior appointments. 'The programme offers something for anyone looking to grow their career,' she adds.

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professional lives
Events, people and support for finance practitioners

Remuneration reports face scrutiny in annual report and accounts audit

Technical

The draft accounts for the 2021/22 financial year were all submitted to the regulatory bodies on time and the auditors have started work, *writes Debbie Paterson.*

It is early days yet but, as expected, auditors are focusing on accruals and provisions, capitalisation of expenditure, cut-off of capital expenditure, valuation of non-current assets and the regularity of special payments.

One area that is perhaps coming in for more scrutiny than usual is the remuneration report. This is partly because of new guidance, but also due to the comptroller and auditor general's qualification of the regularity opinion on NHS England's group accounts for 2020/21.

NHS bodies have included a fair pay disclosure in their remuneration accounts for almost a decade now.

However, the requirements for companies to include pay ratios came into force from 2019 through an amendment to *The Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008*. The new requirement is to disclose the following.

- The percentage changes in the highest paid director's:
  - salary and allowances
  - performance pay and bonuses payable.
- For employees of the entity taken as a whole, the average percentage changes from the previous financial year of:
  - salary and allowances
  - performance pay and bonuses payable.
- The ratio between the highest paid director's remuneration and the pay and benefits of the employee on the 25th percentile and the 75th percentile of pay and benefits of the entity's employees for the financial year.

The highest paid director's salary should be consistent with the existing disclosures in the table of single total remuneration for senior managers. Employees' pay and benefits should include remuneration paid to agency staff and other temporary employees, but should exclude consultancy staff.

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Detailed guidance that provides more detail on the new calculation has been published as part of the guidance supporting the *Financial reporting manual.*

Although that guidance is written for the preparers of government departments' remuneration reports, it provides useful background for NHS bodies.

Early feedback from auditors is that the new disclosures and calculation may need further work to ensure that they meet the new reporting requirements.

The other area where the guidance has changed is in relation to the disclosure of senior managers' pension arrangements, where the individual has opted out the NHS pension scheme.

Some NHS bodies received qualified audit reports in 2020/21 because they could not disclose the pension information for senior managers who had opted out of the scheme before 1 April 2020. The guidance has been updated to avoid this issue occurring again.

FAQ 3 updates paragraph 3.155 of the *Group accounting manual* (GAM) to make it clear that where a senior manager has not been a member of the NHS pension scheme for the full financial year, then no disclosures relating to the NHS pension are required other than a simple narrative statement saying that they are not members of the scheme.

Where the NHS body has made contributions to other pension schemes, those should be disclosed in accordance with the GAM as part of that individual's remuneration.

Finally, regulatory bodies and auditors will be looking more closely at exit packages, not only to ensure that they are properly disclosed, but also to determine whether they include any special severance payments.

Special severance payments are those that are above the contractual and legal requirement. They must be approved in advance of being agreed with the individual. Special severance payments that are not approved will be irregular and will therefore attract a qualified regularity report no matter the size of the payment.

Approved special severance payments must be disclosed in the losses and special payments note as well as the note on exit packages.

Debbie Paterson is HFMA policy and technical manager

Technical review

Recent technical developments

Technical

NHS England and NHS Improvement published details of minimum NHS contributions to **better care fund** (BCF) plans in May. The worksheet shows NHS contributions to the BCF from integrated care boards to individual local authorities as well as overall contributions from each ICB to the BCF across all local authorities in their area. Following the passage of the Health and Social Care Act, from 1 July ICBs will be responsible for ensuring the annual target is met, taking into account any contributions made by their predecessor clinical commissioning groups in the first quarter of the year.
hfma.to/jun225

A new **HFMA self-assessment tool** – *Improving NHS financial sustainability: are you getting the basics right?* – helps finance teams to think about the core elements that should be in place to support board assurance over financial sustainability. The assessment comes in two parts. The first assessment uses a small number of statements to prompt thinking about how arrangements should work in practice, giving a rough indication of the relative maturity of sustainability arrangements. This is accompanied by a detailed checklist covering eight different areas, from financial planning and budget-setting to the governance framework and culture. In a letter to integrated care board designate chief financial officers, NHS England and NHS Improvement chief financial officer Julian Kelly said that all systems and organisations would be required to produce a report for their audit committees covering this checklist by the end of August.
hfma.to/jun2211

The Department of Health and Social Care has issued its response to the consultation on the 2021/22 **group accounting manual** (GAM). The response highlights updates and refinements made to the manual. While the 2021/22 GAM uses IAS 17 in accounting for leases, IFRS 16 was adopted on 1 April for the 2022/23 financial year. However, the GAM consultation included questions on a revised IFRS 16 supplement, offering an early indication of the guidance in the 2022/23 GAM.
hfma.to/jun227

The HFMA has updated its example ***NHS charity annual report and accounts***. The changes include amendments to reflect the impact of the second year of Covid-19 on NHS charities, in terms of grants from NHS Charities Together and the resumption of local fundraising. The example also reflects the initial impact of the pandemic in the prior period figures, and the movements are explained.
hfma.to/jun2212

Integrated care boards (ICBs) will begin life with a clean slate, NHS England and NHS Improvement have confirmed as they published a raft of financial documents for the new bodies. Final guidance, *Revenue finance and contracting guidance for 2022/23*, said that predecessor clinical commissioning groups' deficits will be written off if ICBs break-even in each of their first two years. An historical underspend will be retained as a system surplus, which can be used for non-recurrent spending 'subject to affordability and national approval', the guidance added. Other documents set out ICB funding allocations, which showed growth of 3.6% once the new convergence factor is applied. Convergence, which replaces the pace of change policy used in CCG allocations, moves ICBs closer to their fair share funding and ensures the distribution of funding does not exceed the levels set out last year's spending review. The national bodies also published guidance on capital for 2022-25, and elective recovery planning.
hfma.to/jun2210

The HFMA has produced a summary briefing on the **capital guidance** covering 2022 to 2025, which was published by NHS England and NHS Improvement in April. The guidance outlines how integrated care boards should manage their capital programmes and the information they will need to submit to NHS England and NHS Improvement. As in previous years, the 2022/23 capital allocation will be divided three ways – a system allocation, nationally allocated funds, and other national capital allocations.
hfma.to/jun229

The tariff and ceiling set under the **NHS injury costs recovery scheme** increased from 1 April, the Department of Health and Social Care said. The scheme takes payments from compensators following incidents such as road traffic accidents, where personal injury compensation is paid. The new fees cover injuries sustained on or after 1 April. The increase is made annually to reflect hospital and community health service inflation, which is 2.89% for 2022/23. Where an injured person is provided with an ambulance, the fee is rising from £225 to £231, while the charge for NHS treatment without admission is up by £22 to £766. Daily inpatient care increases from £915 to £941 and the maximum charge is now £56,260 (£54,682 previously). The scheme applies to Scotland, Wales and England.
hfma.to/jun228

NHS Shared Business Services (SBS) has launched its updated **hard facilities management (FM) framework**, which it said could save the health service 10% in estates, facilities and capital development spending over the next four years. SBS expects an £800m spend through the framework over the four-year period, meaning potential savings of £80m. The new framework reflects developments in technology since the previous iteration, as well as new carbon reduction measures. It also includes provision for Covid- safe measures, such as partitioning, isolation and social distancing systems.
hfma.to/jun226

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Training

Finance practitioners and healthcare staff studying for HFMA masters-level qualifications will in future learn together as part of a reformatted programme that will start in October, *writes Steve Brown.*

The new approach will see learners from both secondary care and primary care working alongside each other, studying many of the same modules with the same tutors.

The choice of modules will determine if the learner receives an HFMA advanced diploma in healthcare business and finance or a diploma in advanced primary care management.

The revised approach aligns with the move to system working in England. Rather than studying in specific sector silos, learners will in future share a virtual classroom with colleagues from across the whole of healthcare.

The new programme provides access to seven modules, each worth 30 credits, which are studied over a 10-week period.

Completing two modules (60 credits) will lead to an HFMA advanced diploma, while achieving two HFMA advanced diplomas (120 credits) will make learners eligible to apply for an executive MBA top-up programme provided by the University of Northampton.

This MBA programme took in its first HFMA students at the beginning of the year.

Finance practitioners with a CCAB or equivalent qualification would only require one HFMA diploma to be able to access the MBA programme. The first intake for the revised qualifications will be in October, with a second intake in March 2023.

The seven modules (see box right) are led by experienced tutors who have worked at board-level across the NHS and private sector. Tutors lead weekly *Academy live* sessions to support learners during each module.

There are no restrictions in choice of module for diplomas in healthcare business and finance. Those who wish to achieve the diploma in advanced primary care management will be required to select the NHS law, policy and governance module plus any one of the other modules.

More than 300 learners have now achieved a masters-level diploma with the HFMA since the HFMA Academy opened in 2017 as the association's learning centre. Further students are continuing to work towards completion.

Pictured l-r: Gianluca Paderi, Julia McLarty, Sze May Ng, Tracy Parker and John Leipe

The first graduates of the MBA in healthcare finance, which was offered by BPP University as part of the HFMA route to an MBA until the start of this year, attended a graduation ceremony in March this year, having completed their MBAs over recent years (*Healthcare Finance April 2020, page 24* **hfma.to/jun224**). The 'class of 2022' is pictured left.

One graduate, Tracy Parker, is a former winner of the Tony Whitfield Award in 2017. The award is given to student of the year on the HFMA qualifications programme.

Multiple choice

Completing two of these modules leads to an HFMA diploma:

- **Making finance work in the NHS**
- **Managing the healthcare business**
- **Supporting quality care with patient-level costing**
- **Personal effectiveness and leadership**
- **Tools to support decision-making**
- **Creating and delivering value in UK healthcare**
- **NHS law, policy and governance in primary care**

NHS finance careers portal goes live

One NHS Finance

Never has a career in the NHS been more high profile, with the service front and centre in the response to the pandemic. However, knowledge of a finance career in the NHS is limited – an accountancy career is still typically thought of as a role with one of the top accountancy firms or working with an accountancy partnership in the local town.

As part of the One NHS Finance conversation, finance staff told ONF they wanted to promote and celebrate careers in finance to attract new and diverse talent at all levels. In response, ONF has launched its NHS finance careers portal, *One NHS – careers in NHS finance.*

The careers portal will showcase the different entry routes into NHS finance, and what a career in NHS finance can offer. It will also stream live events and workshops to offer advice to those wanting to gain employment in an NHS finance department.

The portal has also been developed to support the way in which ONF interacts with local schools and colleges to promote careers in the professions within the network.

Finance is involved in everything the NHS does and, most importantly, contributes to the care of patients. ONF hopes to showcase this through the website and help individuals find a rewarding finance career of choice within the NHS.

Ultimately, it wants the NHS to be the employer of choice for a career in finance.

• To find out more about the ONF careers portal, visit financecareers.nhs.uk

Diary

For more information, please email events@hfma.org.uk

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

June

09-10 (B) West Midlands: annual conference, Birmingham
16 (B) Eastern: lunch and learn – delivering a green NHS
16-17 (B) North West: annual conference, Chester
16 (B) Kent, Surrey and Sussex: mini summer conference, Lingfield Park Racecourse
17 (B) Northern: annual conference, Durham
20 (B) East Midlands: team building
23-24 (B) Yorkshire and Humber: annual conference, Scunthorpe
24 (B) Northern: energise your time
30 (B) Scotland: breakfast session

July

13 (B) Northern: interviewing skills
13-15 (N) Summer conference, London and online
29 (B) Northern: unleashing creativity and innovation

August

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

September

08 (B) Northern: annual quiz/AGM
15 (H) Introduction to NHS finance for chairs, non-executives and lay members, London
16 (B) South Central: annual conference
20 (I) Introduction to NHS costing
21 (H) ICB strategic planning and allocations
22 (B) London: annual conference
29 (H) Mental health conference, online

October

04 (I) International value symposium
06 (H) Sustainability in the health service – one year from COP26
12 (N) Charitable funds
13-14 (B) Wales: annual conference
13-14 (B) Kent, Surrey and Sussex: annual conference
20 (H) Estates and facilities forum
20-21 (B) South West: annual conference, Bristol
27-28 (B) Scotland: annual conference

November

02 (H) NHS leadership and CEO forum, London
08 (H) Delivering value and efficiencies
16 (I) Costing revolution summit

December

05-09 (N) Annual conference, London and online

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Events in focus

HFMA summer conference
13-15 July, hybrid

James Mackey (pictured), chief executive of Northumbria NHS Foundation Trust and director of elective recovery at NHS England and NHS Improvement, will be speaking at the summer conference. This hybrid event, taking place online and in-person in London, brings together all the HFMA Hub networks, including providers, commissioners, mental health and community organisations, as well as system-level bodies.

Integration and collaboration will be high on the agenda with integrated care systems due to be launched formally on 1 July, and the NHS seeking ways of clearing waiting list backlogs across the service.

The HFMA is offering a choice of face-to-face tickets and online licences. The in-person section of the programme will be held on 14 and 15 July and ticketholders will be eligible for the online event on 13 July. Online-only licences allow whole finance teams to attend the conference virtually, including the workshops on the first day of the conference, and keynote speakers on the second and third.

• Bookings can be made on the HFMA website at hfma.to/jun223

HFMA annual conference
5-9 December, hybrid

The highlight of any year in NHS finance, the HFMA annual conference continues to deliver high-quality content and networking opportunities. Following the success of the 2021 hybrid conference, when finance teams were able to get involved more than ever, the 2022 event will deliver a range of face-to-face and online presentations over five days.

This year will feature a full exhibition, the association's annual general meeting, and the gala dinner with the opportunity to celebrate the best of NHS finance in the HFMA Awards.

Face-to-face tickets will include access to the online learning lab workshops from Monday to Wednesday, as well as the sessions on 8 and 9 December.

Online licences can again be purchased for the whole team, allowing access to events over the five days of conference.

• To book, visit the HFMA website at hfma.to/jun224
The early booker rate for the conference will be available until 30 June.

HFMA reimagined

Association view from Mark Knight, HFMA chief executive

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

My HFMA

It was great to see so many of the association's former leaders and supporters at the opening of HFMA House in Bristol recently (pictured). The completion of our new head office is a big step forward for the association and completes our property ambitions.

Many of you have asked about our conference centre at 110 Rochester Row in the wake of the pandemic. We have fully reopened it and members are most welcome to stop by if they're in central London (please ring ahead).

The facility still gives us the opportunity to run events face-to-face and I'm delighted to see that staff are returning to London. We will be investing in equipment and developing the online streaming capabilities there in recognition of the new online world. We'll also be upgrading what we have, given that the conference centre is nine years old in July.

Our policy on hub seminars and conferences will be to either run face-to-face or online, not both. Hybrid requires significant commitment, so we are saving this for the summer and annual conferences. We know time is important to members, so we have selected only a few hub events to take place face-to-face from September. Events such as the new year lunch will be face-to-face, but most of what we do will be online, reflecting the members' desire for us to be flexible and adaptive to the new world.

We are excited to be running the summer conference at the Millennium Gloucester Hotel in London, with the key supporters dinner at the Science Museum, in July. I urge members to look at this programme as both online and face-to-face tickets are still available. It will be a great opportunity to network and learn together – just like old times – but organisations can also purchase a heavily discounted online experience.

The association is embarking on a new three-year strategy, currently being developed by staff and trustees. Equality and diversity lie at the centre of the strategy, underpinned by our decision to open up membership to bands two to six. This has helped create opportunities for those not previously involved.

HFMA chief executive Mark Knight

But the association wants to do more, recognising the benefits of having a wider range of people around the table. The HFMA is keen to develop opportunities for all members to be involved in its services and activities. Why not get involved in what we have to offer, either locally or nationally?

We are also making a significant investment in a new website to be launched next year, together with a major redevelopment of our e-learning services, some of which are hosted on legacy platforms. In addition, our reformatted qualifications start in September – well worth a look for those interested in getting their experience recognised and accredited.

We hope that by developing new services we will be fulfilling our president Owen Harkin's challenge of 're-imagining HFMA'. In this post-pandemic world we have a long way to go and we can only do it with your support. So a big thank you in advance!

Member news

Almost 2,500 new members in Agenda for Change bands 2 to 6 have joined the HFMA since January. These staff are eligible for free membership and most of the benefits of paying members. For details, visit the HFMA website **hfma.to/jun222**

The HFMA Hub Mental Health Finance Steering Group has vacancies for members employed by the NHS. Working with NHS England and NHS Improvement, the group welcomes applications from under-represented communities, and finance directors and deputies from East of England, South West, South East or the Midlands HFMA branches. Contact **emily.simmonds@hfma.org.uk**

At the first hybrid Eastern Branch/Skills Development Network/One NHS Finance annual conference, five awards were presented.

- Champion of Diversity: Gerri Powell-Jones
- Finance Team of the Year: Queen Elizabeth Hospital, King's Lynn NHS FT
- Student of the Year: Frances Freeman
- Overcoming Adversity: Sue Fox
- Outstanding Contribution: Emily Bosley.

In addition, two new members have joined the Eastern Branch committee: Justine Stalker Booth and Emily Bosley.

Richard Walton has been appointed chair of the East Midlands Branch.

The North West Branch is raising money for Christie Fundraising in memory of Joanne Fitzpatrick. The Christie finance team aims to raise £10,889 this year – equal to the number of days she worked at the trust. To sponsor visit: **hfma.to/jun2214**

hfma

Member benefits

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

Appointments

Mid Cheshire Hospitals NHS Foundation Trust has appointed **Ian Moston** (pictured) chief executive. Currently chief finance officer at The Northern Care Alliance NHS Foundation Trust, he is expected to move to Mid Cheshire in the autumn. Finance director **Russell Favager** will continue as interim chief executive, while deputy finance director **Ros Davies** is acting director of finance.

Chris Moreton, former assistant director of commissioning and finance at NHS Wales, has been named deputy director of finance at Velindre University NHS Trust.

Liverpool Heart and Chest Hospital NHS Foundation Trust has appointed **Karan Wheatcroft** (pictured) director of risk and improvement. She joins the trust after more than 20 years at Mersey Internal Audit Agency, latterly as executive director of operations.

James Thirgood is now finance director – financial management at Mid and South Essex NHS Foundation Trust, moving from The Princess Alexandra Hospital NHS Trust, where he was deputy director of finance.

Audit Scotland has appointed **Vicki Bibby** chief operating officer. She is due to join the auditor in late summer from Public Health Scotland, where she is director of strategic planning and performance. She has also served as head of resources and chief finance officer at the Convention of Scottish Local Authorities.

Mike Townsend (pictured) has been named managing director of Barts Assurance, the new name for London Audit. He was regional managing director of business assurance firm TIAA. Services will be delivered through two complementary teams, Barts Internal Audit and Barts Investigation Services. The latter will oversee disciplinary cases and bullying allegations.

Nik Khashu is the new North West region director of finance. He moved to the region in April from St Helens and Knowsley Teaching Hospitals NHS Trust. The trust has named **Gareth Lawrence**, previously deputy director of finance and information at the trust as director of finance and information.

ICB finance directors

As *Healthcare Finance* went to press, these appointments were confirmed:

	Designate FD/CFO	Previous organisation
North East and Yorkshire: four ICBs		
North East and North Cumbria	Jon Connolly	North Tyneside CCG
South Yorkshire and Bassetlaw	Lee Outhwaite	Chesterfield Royal Hospital NHSFT
West Yorkshire	Jonathan Webb	Wakefield CCG
North West: three ICBs		
Cheshire and Merseyside	Claire Wilson	Wirral University Teaching Hospital NHSFT
Greater Manchester	Sam Simpson	Tameside and Glossop Integrated Care NHSFT
Lancashire and South Cumbria	Sam Proffitt	Lancashire and South Cumbria ICS
Midlands: 11 ICBs		
Lincolnshire	Matt Gaunt	Lincolnshire CCG
Birmingham and Solihull	Paul Athey	Birmingham and Solihull CCG
Northamptonshire	Sarah Stansfield	Northamptonshire CCG
Shropshire, Telford and Wrekin	Claire Skidmore	Shropshire, Telford and Wrekin CCGs
Black Country	Tom Jackson	Dudley Group NHSFT
Staffordshire and Stoke-on-Trent	Paul Brown	Staffordshire and Stoke-on-Trent CCGs
East of England: six ICBs		
Bedfordshire, Luton and Milton Keynes	Dean Westcott	Bedfordshire, Luton and Milton Keynes CCGs
Cambridgeshire and Peterborough	Nicci Briggs	Leicester, Leicestershire and Rutland CCGs
Hertfordshire and West Essex	Alan Pond	Herts Valleys CCG and West Essex CCG
Norfolk and Waveney	Steven Course	East London NHSFT
South West: seven ICBs		
Bath, North East Somerset, Swindon and Wiltshire	Gary Heneage	NHS England and NHS Improvement
Bristol, North Somerset and South Gloucestershire	Sarah Truelove	Bristol, North Somerset and South Gloucestershire CCGs
Dorset	Rob Morgan	Frimley CCG
Gloucestershire	Cath Leech	Gloucestershire CCG
South East: six ICBs		
Frimley	Richard Chapman	Derby and Derbyshire CCGs
Kent and Medway	Ivor Duffy	Kent and Medway CCG
Surrey Heartlands	Matthew Knight	Surrey Heartlands CCG
Sussex	Hannah Hamilton	NHS England (south east)
London: five ICBs		
North Central London	Phill Wells	Homerton University Hospital NHSFT
South East London	Mike Fox	Central London Community Healthcare NHST
South West	Helen Jameson	Great Ormond Street Hospital for Children NHSFT

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

"UHS is a world-class organisation that feels like a family that is all pulling together in the same direction"
Ian Howard, Unversity Hospital Southampton NHS FT

CFO role for Howard at 'world-class' UHS

On the move

As the new chief financial officer of University Hospital Southampton NHS Foundation Trust (UHS), Ian Howard is already immersed in the trust's culture, having joined in 2017 and stepped up to interim CFO in November 2020.

'I have a strong emotional connection to the trust and very much feel part of the UHS family,' he says. 'I have immense pride in the improvements we have made in recent years, the developments we have created and the culture we have facilitated and grown.

'This has been demonstrated by the innovative, forward-thinking but, most importantly, caring response to the pandemic – putting care of our staff and care of patients at the forefront of everything we do.'

Despite recent challenges, the results from the trust, reduced infections and lives saved, have highlighted everything that is special about working for UHS.

'The compelling attraction to working for UHS is supporting a world-class organisation that feels like a family that is all pulling together in the same direction,' he adds.

'The role of CFO gives me the opportunity to provide the financial leadership and infrastructure within UHS and the wider health system to really make a difference to staff and patients, and to achieve the trust's vision of "World class people, delivering world class care".

UHS is developing a finance strategy to describe how the vision is supported, building on a strong track record of financial performance to maintain financial sustainability and invest in the trust's underlying infrastructure. This includes improvements to capacity and estate and investing in digital.

'We are also supporting system developments, including how we collaborate via clinical networks. To achieve this strategy, we will need to innovate, identify new funding sources, and create commercial agreements, as well as utilise our assets effectively,' Mr Howard adds.

The NHS has faced the most challenging period in its history and must now address the equally daunting task of recovery.

'We know patients are waiting too long for care, and that leads to poor experiences for patients, their families and staff. We also know staff have faced unprecedented pressure during Covid and need us to be compassionate and caring in supporting their recovery.'

At the same time, the finances of the NHS have tightened, with funding increases during Covid not being sustained.

'Our challenge is therefore to keep our responses to these pressures aligned and in balance. Within finance, our priority is to develop the financial architecture to support the additional activity while maintaining financial sustainability,' he adds.

Despite ongoing pressures, the NHS must not lose sight of the longer term, he says. 'In these challenging times, it is so easy to fall into the trap of only thinking of the here and now; how do the next few months look?

'However, the task facing the NHS is not a short-term one. If we are to reduce waiting lists by delivering 130% of pre-Covid elective activity in future years, we have to act now to ensure we have the capacity and workforce in place. Continuing to develop our future workforce – including finance professionals – is key to responding to these challenges in the future.'

Mr Howard joined the NHS in 2007 on the national graduate training scheme, then held various finance roles with commissioners.

In 2013 he moved to NHS England during its formation, giving him a wider understanding of the NHS at different levels.

At that point in his career, he wanted to be closer to patients and frontline staff, and to feel he could make a difference. In 2017, he joined UHS as assistant director of finance, before being promoted to deputy director of finance in 2018. And, after 14 months as interim CFO, he was appointed permanent CFO in March.

'After the previous CFO was promoted to chief executive, I was asked to step into the interim CFO position. This came early for me, but the opportunity to gain experience of operating at that level, with fantastic support from the CEO and wider executive team, was one I couldn't turn down.'

Mr Howard adds: 'Being honest, the first few months were daunting. However, the support I have received during the sharp learning curve has been fantastic. This has enabled me to grow into the role and be appointed to the permanent CFO position.'

The NHS graduate management training programme played a big role in his career. 'It launched my career in the NHS and my passion for making a difference in healthcare. I was lucky enough to have the support of programme and placement managers who are passionate about growing the future NHS finance leaders and helped my development, giving me a broad range of experience I look back on to this day.

'The scheme kick-started my career with direction and purpose, and I am truly grateful for the experiences it gave me.'

He strongly believes in finance staff development, and has made it one of his priorities.

'In UHS, we have a concept of finance staff leaving footprints throughout the organisation, where we encourage change and innovation, and support teams to make a difference. For that to be a reality, we must develop and empower our staff at all levels throughout the finance function.

'We hope that the finance staff we are developing will be our future finance teams and finance leaders. My journey is a testament to that model, and I hope I can give back by supporting the development journey of budding finance professionals within UHS and the local healthcare system.'

PRiME

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13 - 15 July 2022, London, Millennium Gloucester Hotel

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