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

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

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

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

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
Seacourt

HFMA
1 Temple Way,
Bristol BS2 0BU

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

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

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

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PRIME

Why Integrated Health and Care services are the social and economic allies our high streets need

Reimagining our town centres
Traditional bricks and mortar retailers that were once the beating heart of our town and city centres entered 2020 on already shaky ground as a result of the digital disruption that is ecommerce, only to take further painful hits during the pandemic. While the personal cost to employees, retail business owners and landowners has sadly been high, we have to accept that the high street has changed forever.

The reality of this commercial disruption is also a pivotal moment for health and care providers. It presents a chance for leaders to assess the opportunities that arise from the current economic and social changes and embrace urban locations as viable and accessible spaces for health and care services.

So what might a post-retail landscape look like?
The regeneration of our high streets is a necessity that is both of the moment and also long-overdue. While the COVID-19 pandemic has sped up the demise of these long-established spaces within our communities, it has also refreshed our collective focus on health and care. Falling property values and the exit of 'traditional' retail and leisure occupiers, makes health and care investment within our towns an affordable and deliverable reality.

When the longed-for rhythm of our lives returns, what will attract people back to the high street are dynamic local interests that can't be satiated within the confines of our increasingly digital world. A mix of businesses that better reflect the characteristics of the local community will have the opportunity to thrive, positioned alongside integrated health services, community resources and contemporary urban accommodation.

Services and attractions that may once have been priced out of urban centres and forced into tertiary locations now have the opportunity to relocate into new purpose-built spaces that balance commercial and community needs. While health and care services have always suited town centre locations, they've rarely been able to afford these prime spots. With tailor-made buildings in accessible town centre locations, we have the potential to co-locate vital health, care and advice services with community spaces and leisure facilities; tackling health inequalities and shifting a focus away from the treatment of illness to the promotion and nurture of wellness.

Flexible spaces, fit for the future
The demographics of the UK are changing rapidly, with people over the age of 65 set to increase from 12m to 16m by 2036 and so far the UK has failed to create suitable housing environments for this age group. With greater levels of disposable income and an aspirational desire to be better connected to social amenities and facilities, it makes commercial sense to create a vibrant mix of purpose-built accommodation, retail and community facilities that breathe life into our high streets and local economies once more.

The success of regeneration projects across the globe has shown that a focus on later living generates opportunities for the rejuvenation of spaces and services that can benefit the whole community. Developments like the Belong Care Village in Newcastle-Under-Lyme, that transformed a derelict urban space into a vibrant hub with close links to and benefits for the wider community.

Shared vision and shared costs
Unlike piecemeal and disjointed initiatives that have seen GP facilities or walk-in centres occupy the shell of vacant retail space, the concept of Urban Health and Care Villages requires wider collaboration. By uniting around a common goal, health leaders, asset managers, local authorities, investors and the community alike can share the costs and challenges of repurposing city centre spaces. With a shared aspiration to reimagine how commercial and community interests can coexist, this moment provides an opportunity to bring about affordable and achievable change to our health and care services.

Turning theory and conversation into action with Prime
Prime understands that at the heart of every successful regeneration scheme there is a community that feels reflected in the design and development. By shifting from homogenous high streets to community villages, these spaces have the potential to improve the physical and mental health of all ages and create community cultures that bridge the gaps between generations. The development of integrated spaces that unite selected outpatient services with primary care services on our high streets is already a viable success, delivering a multitude of benefits to communities and trusts alike. However, with wider collaboration from town centre stakeholders, we can open the door to transformative economic and social regeneration in a way that hasn't been possible before.

As well as understanding the needs of communities and empowering them to be part of the regeneration process, Prime is also best placed to understand the needs of landowners, health and care providers, planners and investors. With more than twenty years' experience, the Prime team and I are excited by the scale of opportunity that lays before us, to not only theorise about the regeneration of our towns, cities and health care services, but to deliver action-focused results.

It's time for us to unlock this opportunity together.

Leighton Chumbley
Chief Executive, Prime

News

2021/22 finance arrangements delayed to support Covid effort

Above: Julian Kelly
Left: Emma Knowles

By Seamus Ward

NHS bodies in England will enter the new financial year knowing the financial regime could change in-year, with NHS England and NHS Improvement confirming that financial arrangements established for the second half of 2020/21 will be extended into the first quarter of the new financial year.

Operational guidance issued to the service in January said: 'Due to current pressures, we are planning to roll over current financial block contracts for Q1 2021/22 and therefore will not be initiating a planning and contracting round with a changed financial framework before the start of the year.'

It added: 'We cannot confirm total funding for Q1 as that will be subject to discussion with the government, but systems should not take any steps that would reduce capacity and the ability to respond to Covid-19 in anticipation.'

Under current arrangements, systems are allocated funding envelopes and expected to break even overall. Individual organisations can plan for a surplus or deficit with the agreement of the other organisations in the system. Funding flows to providers through block contracts.

The planned financial framework, including a move to blended payments, will be delayed. Engagement on the national tariff issued in February said the 2021/22 financial framework would support financial governance and cost control at a system level.

The introduction of blended payment and system top-up allocations to cover the cost of delivering services efficiently was among the measures planned to support this.

NHS England vice chair David Roberts said the decision to suspend operational planning for the first quarter was 'sensible' and the national bodies will start thinking again about the financial framework in the new financial year.

HFMA policy and research director Emma Knowles said: 'In light of the current pressures on the health service, delaying the implementation of the 2021/22 framework is a reasonable and pragmatic step. However, finance managers will hope to see details of the system they will be operating after June as soon as possible, to give them some certainty when planning for the rest of the year.'

> **"Finance managers hope to see details of the system they will be operating after June as soon as possible"**
> Emma Knowles, HFMA

While future financial arrangements are aimed at further supporting the move to system-wide care, in February the government published greater detail on reforms that will make integrated care systems (ICSs) statutory bodies.

A white paper said ICSs would be made up of two bodies: the ICS NHS body, which will discharge most of the functions currently provided by clinical commissioning groups; and the ICS health and care partnership, a group of local health and social care organisations that will develop system plans.

NHS England will set financial allocations (capital and revenue) at system level, with the ICS allocating this funding according to its plans. ICS NHS bodies will not have power to direct trusts, which will remain separate, statutory bodies, retaining their current financial statutory duties.

But providers will have a new duty compelling them to have regard for system financial objectives, to ensure all local bodies have a stake in achieving financial control at system level, the white paper said.

There will be a new power for NHS England – as the merged NHS England and NHS Improvement will be known – to cap foundation trust capital spending.

This would only be used in response to a potential breach of spending limits. Capital spending controls are in place for NHS trusts and foundation trusts in financial distress only, though foundations' capital spend counts against the Department of Health and Social Care's capital departmental expenditure limit (CDEL).

If a foundation trust pressed ahead with a capital scheme without regard for system capital envelopes or national CDEL, other developments may have to be suspended, the Department said. And while negotiation was its preferred solution, there will be reserve powers to impose a legally binding capital limit on individual trusts. This differs from a 2019 proposal to place annual capital resource limits on all foundations.

Speaking in January about the NHS financial position at month 8, NHS England and NHS Improvement chief financial officer Julian Kelly said he expected full year capital spending for 2020/21 to be in line with plan. At that point, providers had spent £2.8bn on capital schemes.

Covid-19 had cost the NHS in England £9.7bn more than its original mandate by month 8, he said – £2bn more than at month 6. This does not include most of the extra cost of personal protective equipment and NHS Test and Trace, which are being funded by the Department.

There were small underspends in CCGs and central admin and running costs, but the provider sector recorded an adverse impact of £5bn. Mr Kelly said the NHS was spending more than it would have received under the long-term plan mandate. 'That is consistent with the trend we have seen through this year, as we have dealt with the impact of Covid, the extra capacity we've had to buy, financial arrangements for the discharge scheme, as well as the loss of income to the NHS that's happened as a result of Covid.'

Central government supplementary supply estimates for 2020/21, published at the end of February, show that the Department of Health and Social Care received a net increase in its resource departmental expenditure limit of £57bn, largely to meet additional Covid-19 costs. This included £20bn for NHS Test and Trace, £15bn for personal protective equipment and £3bn for vaccine deployment. NHS England's expenditure limit increased by £12bn.

Audit report has potential impact on 2020/21 accounts

By Seamus Ward

The recent National Audit Office report on the Department of Health and Social Care's 2019/20 accounts may have been unusual in that auditor and Department have openly disagreed. But it also raised other issues that could have ramifications for the 2020/21 accounts, which will be finalised over the next few weeks.

The auditor qualified the Department's core department and agencies statement of financial position for 2019/20. This does not include the financial position of the wider departmental group, which was not qualified.

The qualification is due to a misstatement – in the auditor's view – of the value of loans from the Department to providers.

The NAO and the Commons Public Accounts Committee has raised concerns over loan repayment for a number of years.

NAO comptroller and auditor general Gareth Davies said the trusts' financial position is the most relevant indicator of their ability to repay the loans.

He argued that trusts became an increased credit risk where their financial distress presented as negative net assets or, in some cases, the agreement of new repayment plans. An impairment was required to avoid a material misstatement of £2.2bn, which was calculated after examining the net asset position of every trust that had received loan finance from the Department.

The Department disagreed with the auditor's position, insisting that the repayment of outstanding loans in September 2020 demonstrated the loans were not impaired.

However, in his report, Mr Davies notes that the repayment was only possible due to the issue of new public dividend capital (PDC) from the Department itself. It is unlikely that this will have an impact on 2020/21 as the loans have been repaid and PDC policy has changed – now, PDC will be impaired where a provider's net assets are lower than the PDC issued to it.

Issues raised on regularity did not lead to a qualification, but could have an ongoing impact. First was the auditor's view that 'ministerial direction does not make regular what would otherwise be irregular'.

In the 2019/20 accounts, this related to senior clinicians' pensions, though ministerial direction on Covid-19 spending will be examined closely in the 2020/21 accounts.

In 2019/20, doctors reduced hours, turning down overtime and even considering retirement due to pension tax rules that left them with large potential tax bills. A ministerial direction was made on pensions to ensure there were enough senior doctors over winter as the solution risked breaching *Managing public money*.

The auditor said, even with the direction, the payments were irregular, as they were a form of tax planning that will leave the Exchequer worse off. However, the regularity opinion was not qualified as the cost was not material, had been fully disclosed in the accounts, and the decision was made transparently.

Gareth Davies (pictured) said the report on the 2020/21 accounts will focus on 'new areas that exhibit new and significant risk'

A further ministerial direction was made at the end of March 2020 to meet the government promise that the NHS would receive the funding it needed to tackle Covid. This was not needed in 2019/20, but Mr Davies said the report on the 2020/21 accounts will focus on 'new areas that exhibit new and significant risk' – including NHS Test and Trace, the procurement and storing of personal protective equipment, and the Covid-19 vaccination roll-out. All NHS bodies should expect to justify new areas of spend and to discuss the governance arrangements with their auditors.

Mr Davies also highlighted financial reporting and governance issues at University Hospitals of Leicester NHS Trust (UHL), which he called 'unprecedented'. The trust had failed to prepare true and fair accounts, and to maintain appropriate accounting records. Issues at the trust indicated management override of internal control, he said. There was an unusually high level of manual interventions in the accounting records, including over 270,000 manual journals.

Draft financial statements for 2019/20 included prior year adjustments of £46m, but the UHL auditor identified other issues, such as inaccurate recognition of expenditure and payables, disagreement on technical accounting adjustments, errors in the valuation of the estate, and inappropriate recognition of income.

'The auditor also noted that adjustments appear to have been made in the 2018/19 financial statements at the request of UHL's management to achieve a certain outcome rather than to represent accurately the economic reality of transactions into which UHL entered,' the report added.

In previous reports, the NAO has raised concerns about local management overriding internal controls to meet control totals. Although there have been no control totals in 2020/21, auditors will be concerned about changes to financial governance arrangements made at pace as well as new financial systems put in place during the early days of the pandemic.

The UHL trust board has been unable to sign off the 2019/20 accounts, and hopes to produce a revised set by late spring. This will have a knock-on effect on its 2020/21 accounts – it will miss the June deadline but hopes to have completed them by 31 August. The trust's chief financial officer and chief executive have now left the trust, with NHS England confirming they have referred both to the Care Quality Commission under the fit and proper person process, and in the case of the ex-CFO to the relevant accounting professional body.

The trust's new CFO Simon Lazarus said: 'Due to the scale and complexity of the task this work is still ongoing, but a huge amount of progress has already been made. I have also been able to strengthen the finance team and improve the financial governance processes of the trust with the support of the board.'

Trust chair Karamjit Singh said that the board took full responsibility.

'The trust board takes this very seriously,' he said. 'And although the auditor general refers to the "accounting judgements and manual intervention associated with the previous senior leadership regime", I am clear the responsibility for exposing and addressing these issues sits with me and my board colleagues.'

New anti-fraud standards to be implemented in April

By Seamus Ward

From next month, finance directors and audit committees across England and Wales will be required to oversee a revised set of counter-fraud actions, some of which are new.

The updated requirements stem from the updated government functional standard on counter fraud, which replaces previous NHS standards for fraud, bribery and corruption. The new functional standard has now been interpreted by the NHS Counter Fraud Authority (NHS CFA), producing a list of 12 requirements that will apply from 1 April.

The 12 components include producing a counter-fraud, bribery and corruption strategy to be submitted to the counter-fraud body; introducing outcome-based metrics; and having an accountable board-level individual.

The National Audit Office has challenged the government to take greater action against fraud. The standard is its response – developed by the Cabinet Office – to 'ensure that government organisations have a robust and co-ordinated approach to protecting public services against the risk of fraud, bribery and corruption.'

The NHS CFA estimates the NHS is vulnerable to more than £1.2bn worth of fraud each year.

The new requirements apply to all NHS-funded bodies in England and Wales, including NHS trusts, foundation trusts, clinical commissioning groups, health boards, ambulance trusts, some independent sector providers, NHS England and NHS Improvement. If they meet qualifying criteria, trust subsidiary companies may also be subject to the new requirements.

'The focus is governance, identification, prevention and recovery,' said NHS CFA quality and compliance manager Paul Tiffen (pictured).

He said that for around the last 10 years, the NHS CFA and its predecessors had developed a series of counter-fraud standards, which it supported the NHS to achieve. But the Cabinet Office has been leading a growing counter-fraud community across the public sector, and hopes the new standard will see common, high-quality anti-fraud work across the whole public sector.

The NHS CFA had been able to add its ideas and NHS experience into the development of the standard, and had now interpreted it for use in the health service.

'Our whole philosophy was one of evolution rather than revolution,' said Mr Tiffen. 'We didn't want to change too much; we didn't need to change too much. We wanted to bring people along with us to get the wider government standards incorporated into the NHS.'

The Cabinet Office wants the standard of counter-fraud work across the public sector to increase long term, but this should be balanced with more incremental change.

'It didn't want people's heads to go down by trying to run too quickly – it's trying to do it in a sensible way, but at the same time one that shows progress,' said Mr Tiffen.

However, the new Cabinet Office standards have diverged in some areas from those already in use by the NHS. And with 12 new categories, requirements already in place in the health service have been moved around to fit the new structure. To help NHS organisations, the NHS CFA has mapped its previous counter-fraud standards to the new requirements.

Outcome-based metrics is one example of a new requirement and should be produced as part of an annual counter-fraud action plan. Organisations should define the outcomes they are seeking to achieve each year, together with the metrics they will use. Those with a significant counter-fraud investment and those with a significant estimated fraud loss should include financial impact metrics. These metrics should, for example, be based on a targeted value of prevented and/or detected fraud against a baseline to measure improvement.

'We want organisations to take a more risk-based approach,' Mr Tiffen said. 'The NHS is massive, and organisations are varied. There isn't a one-size-fits-all approach you can take.'

Each NHS-funded body must provide details of their performance against the 12 requirements – and thus the standard – annually. The NHS CFA will use this to provide assurance to the Cabinet Office of NHS action against fraud, bribery and corruption.

Paul Tiffen: governance and recovery

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NHS organisations should identify risks, and based on this, develop targets. He added that the metrics were important as they will feed into the authority's overall targets. 'Broadly speaking, this is broken down into the amount of fraud they identify and the amount of money they can recover as a result of that.'

The NHS CFA strategy is to recover £400m overall in the next three years, and it hopes local organisations will contribute to meeting this aspiration.

Mr Tiffen urged NHS-funded services to prepare for the new requirements. 'They should familiarise themselves with the requirements. This is not revolution. Directors of finance and audit chairs should be ready to challenge the individuals operating counter fraud work locally, and support them as they prepare to meet the challenge of achieving the new requirements.'

He acknowledged that the counter-fraud community faced challenges due to the Covid pandemic. Some people have been diverted from their work to support the Covid-19 effort, for example, and while this work is important, the pandemic offers opportunities for fraudsters.

'We have seen a massive increase in e-procurement, for example, over the last 12 months and, understandably, these things were done quite quickly. Sometimes fraud can creep up when things are done quickly,' he said.

Mr Tiffen paid tribute to local NHS bodies for their engagement with the NHS CFA's work to adapt the standard for health service use.

'This is not something you can cook up in isolation,' he said. 'We reached out to the local counter-fraud community, directors of finance and audit chairs, and I would want to acknowledge their input into this.

'The NHS CFA is responsible for providing assurance to the Department of Health and Social Care and the Cabinet Office regarding overall compliance with the functional standard across the sector, and will be working collaboratively with NHS bodies to enable them to comply with the requirements.'

News review

Seamus Ward looks at recent developments in healthcare finance

Covid continued to be the main focus of the NHS over the winter, as infections, hospitalisations and deaths rose, but there were positive signs as spring approached. The prevalence and impact of the virus reduced as the lockdowns and the vaccination campaign gained pace, culminating in the government four-step roadmap to lifting restrictions. Pupils in England will go back to school on 8 March, followed by grassroots sport on 29 March, as part of a two-stage first step. If four tests are satisfied, there will be further moves in five-week intervals, promising a return to some semblance of normality by June.

Unsurprisingly, with elective capacity reduced, waiting lists have lengthened and around 4.5 million people are now waiting for routine surgery. NHS staff and managers are all too aware of this and a group of NHS leaders, led by the NHS Confederation, wrote to the prime minister in February urging the government to be realistic about the recovery period. Staff should be able to take time off to recover and receive ongoing mental health support. The government should be clear with the public about when routine services will be fully back to pre-Covid levels, they said. The 52-week waiting time standard for elective care should be suspended and replaced with a patient-centred approach focusing on clinical need. At the end of December 2020, nearly 225,000 people were waiting more than 52 weeks for planned surgery compared with just over 1,600 a year earlier.

The NHS in Scotland was warned that it will be difficult for the service to address recovery and reduce waiting lists against a backdrop of financial and operational pressures already present before the pandemic. An Audit Scotland report said the Scottish government and health service acted quickly in responding to Covid-19, but could have been better prepared. It also looked at the local NHS finances, noting that while all health boards achieved financial balance in 2019/20, four needed additional financial support from the Scottish government. The Covid pandemic had led to significant additional spending in 2020/21, though allocations have been revised and health boards will be fully funded to deliver financial balance in 2020/21. The auditor added that the pandemic affected savings programmes, though savings trajectories will be reviewed in 2021/22.

With thoughts turning to NHS recovery, NHS Employers said the NHS can play a key role in supporting the turnaround of local economic fortunes. A briefing said that despite rising unemployment, the health service faces ongoing workforce shortages. There are a number of government initiatives and funding available to support NHS organisations to recruit from local populations that have been directly impacted by Covid-19. This will ensure recruitment reflects local diversity and offers opportunities for good-quality work and careers in the NHS.

In late January, the Scottish government announced that health in Scotland will receive a 5.3% cash increase in 2021/22, with a further £869m to tackle the impact of Covid-19. In the Scottish Budget, core health and sport funding will rise by more than £800m in 2021/22, taking the budget to more than £16bn. In total, health boards will share £11.9bn, including £10.6bn for territorial health boards and £1.3bn for the national boards. There will be £1.9bn for primary care and £1.1bn for mental healthcare. The boards will get £500m in capital funding.

The Northern Ireland executive also announced a draft Budget, increasing the Department of Health's budget to almost £6.6bn in 2021/22. However, the Department believes the 5.7% rise (compared with the 2019/20

The month in quotes

'Health leaders will continue to prioritise urgent care and patients with the greatest clinical need, but staff are on their knees and many of the pre-pandemic challenges are still very much at play. We are calling on the prime minister to be up front with the public about what the NHS can safely deliver.'
NHS Confederation policy director Layla McCay says the government must be realistic about NHS recovery

The fact that the available recurrent mainstream resource funding has only marginally increased means it will not provide a basis for the sustainable rebuild of our health service.'
The Northern Ireland Department of Health says sustained investment is needed to rebuild services and reduce waiting times

'The challenge for each individual body is to fully evaluate their new ways of working, consider the opportunities and maintain the sense of urgency and common purpose created during the crisis to establish and embed new approaches to governance.'
Wales auditor general Adrian Crompton says positive governance innovations made in the pandemic should be maintained post pandemic

'Getting the full range of health services back up and running will be challenging. But there are clear lessons to be learned from the pandemic, both in how the country could have been better prepared and in the innovation we've seen. It's essential these advances are now retained and built upon.'
Stephen Boyle, auditor general for Scotland, on the battle ahead to recover NHS services

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baseline), is not enough to meet rising demand and the growing needs of an ageing population. A Department budget document said only £52m of the proposed settlement represents additional recurrent mainstream funding – and this sum has been earmarked to cover Agenda for Change pay increases. It will be challenging to manage the budget against demand, particularly given the pressure on costs prior to the Covid-19 pandemic, the document said.

A Treasury waiver in Northern Ireland means the health department can build up PPE stock for use in the next financial year

There was better news from the Department when it disclosed that a Treasury waiver on the accounting treatment of personal protective equipment (PPE) stock will allow the Northern Ireland Department of Health to spend £175m in 2020/21 on supplies that can be used in 2021/22. Health minister Robin Swann said consumables are usually counted as expenditure as they are used, but the concession will mean his department can build up stock for use in the next financial year. The Department had previously returned £90m of Covid funding that could not be spent on PPE at the time.

Audit Wales praised the Welsh NHS for its governance during the pandemic. It said good governance has been largely maintained by Welsh NHS bodies during Covid. In a report, *Doing it differently, doing it right?*, the audit body said Covid-19 had led to a range of changes in the way NHS organisations are governed. These included the introduction of online meetings, more oral reporting, and streamlined agendas. Not only had this maintained effective and efficient governance, but it had also highlighted potential changes. NHS bodies should consider the benefits of retaining some of the changes post-pandemic, including the potential enhancements in public engagement and transparency in holding online meetings.

The Department of Health and Social Care told the Senior Salaries Review Body (SSRB) it is not seeking pay recommendations for 2021/22. The SSRB's remit has now been extended to include all very senior managers in the NHS and executive and senior managers in the Department's arm's length bodies. In a letter on the body's remit, health and social care secretary Matt Hancock told the SSRB that public sector pay rises in 2021/22 will be limited and targeted. But he added that work carried out by the SSRB this year would 'play a key role in positioning senior health manager pay for future years'.

The government has published its proposals to address the discrimination identified in the transitional protection in the 2015 reforms to public service pension schemes. This included the NHS pension scheme. In 2018, the Court of Appeal ruled there had been discrimination, with younger members of the scheme not offered transitional protection. The government said it would now offer members of legacy schemes between 1 April 2015 and 31 March 2022 a deferred choice. Those retiring after March 2022 can choose at retirement whether to take benefits from the legacy or reformed scheme – for those retiring before 31 March 2022, a choice of benefits will be given as soon as practicable, the government said.

from the hfma

The HFMA continues to publish regular blogs online highlighted in *Healthcare Finance weekly*, covering topics from mental health to audit, and Brexit to the future role of the finance profession.

HFMA policy and research manager Sarah Day examines proposals for mental health legislation, which would put patients at the centre of decision-making. Dignity is key to wellbeing and health, and the plans go some way to addressing that, but appropriate funding, better facilities and an enhanced workforce will also be needed, she says.

Lee Outhwaite, director of finance at Chesterfield Royal Hospital NHS Foundation Trust, looks at the measures needed in the new financial regime in England to support integrated working. Writing ahead of the government white paper, he points to an HFMA report setting out member views on how the regime should look, especially around transparency and the ownership of risk.

With the UK exiting from the European Union on 1 January after completion of the transition period, Mark Dayan, Nuffield Trust Brexit programme lead, argues that a smaller economy – as forecast by the Office for Budget Responsibility – will likely mean less money for public finances.

Five very different issues are raised in the audit report on the Department of Health and Social Care's 2019/20 accounts, and those relating to the regularity opinion could have an ongoing impact, says HFMA policy and technical manager Debbie Paterson. These include ministerial direction on pension tax arrangements, special payments and the 'unprecedented' issues with one trust's accounts (see News, page 4).

See www.hfma.org.uk/blogs

Comment

March 2021

Painting by numbers

Annual accounts offer an opportunity to tell the tale of a pandemic in the financials

HFMA president Caroline Clarke

Many people reading this will be thinking about their financial year-end, and how to prepare for the end of a year like no other.

That's a really interesting part of our job – to tell the tale of a pandemic in the financials and do it in a way that gives a true sense of what happened. It's easy to get caught up in the vagaries of accounting standards and changes in policy, and sometimes we can lose the transparency of what the numbers actually tell us.

Let's remember that we are accounting for a truly exceptional year, with truly exceptional costs. We owe it to our stakeholders, and to ourselves, to paint that picture in as clear a way as possible in our various annual reports. So good luck to all of you preparing the accounts. It's an important job and the eyes of the public will be upon us!

I'm writing this piece on the day that Scotland announced its route out of lockdown and the day after the English team described lockdown easing here. Like many people, I have mixed emotions. I totally understand why we can't unlock quickly. I still have more than twice the number of patients in my intensive care facilities than normal and the actual disease prevalence is still pretty high.

But I also really want to get a decent haircut and have dinner with my mates. And I'm suddenly craving a visit to the pub in a way that I haven't for years. And a visit to a gym. And a trip out of London. And a chance to visit the various branch conferences in person. In the

Financial recovery

Finance teams will need to refocus on budget management and value delivery

Healthcare Finance editor Steve Brown

The NHS is focused on recovery. Cases of Covid-19 are declining, with the seven-day average more than halving during February. There are still a lot of patients with coronavirus in hospital, but this is also reducing, albeit slowly. So with direct Covid pressure decreasing, the service is increasingly focused on recovering normal levels of activity in non-Covid areas.

The NHS never stopped delivering urgent care, but capacity has been a real issue and some elective services were paused during each of the waves of the pandemic. There are more than 4.5 million people on the NHS waiting list, although there are concerns this could soar as pent-up demand is released into the system. And the numbers waiting over a year has risen to a staggering nearly 225,000.

Resuming normal levels of activity while addressing the backlog is a big priority, with full recovery likely to be measured in years.

Finance departments face their own recovery agenda. The past year has seen the sensible adoption of much simpler financial flows, with a commitment for the first six months to ensure all providers' extra Covid costs were met, enabling them to break-even. Fixed system funding levels were introduced from October, with block contracting arrangements remaining in place.

These mechanisms have been extended for at least the first three months of 2021/22, with the contracting round very firmly on hold.

But a funding flow system with more downward pressure on costs will return, even if the service has seen the last of any tariff-based, payment by results contracts.

The direction of travel is clearly towards blended payment arrangements. While initially this might result in something that looks broadly similar to rolled-forward block contracts, the intent is for future contracts to be set at values informed by local costs.

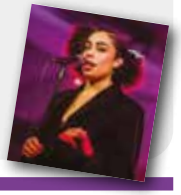
Finance teams will have a major role in implementing these revised arrangements, which will also have to factor in the move to integrated care systems.

Lots of positives have come out of the simpler funding flows over the past year, including greater collaboration across organisations in systems. These good relationships need to be retained, but there will inevitably be tensions as financial envelopes tighten and expectations increase in terms of activity levels to be delivered.

Budgeting and budget management

PRESIDENT'S PLAYLIST

BOOK I've just finished ***Soul tourists*** by Bernardine Evaristo. It has elements of poetry, history and humour and doesn't mention Covid at all, so it's good to switch off with.
TV I've started watching telly again and found a couple of brilliant series: HBO drama ***Succession***, about a family of media moguls and their evil plotting, and ***Call my agent***, a hilarious French drama about a talent agency.
MUSIC I discovered Celeste (pictured) last year and new album ***Not your muse*** has something for everyone – think Nina Simone and Amy Winehouse.
• ***Send your suggestions to president@hfma.org.uk***



"I've been vaccinated and I'm encouraging everyone to go for it – shout out to anyone involved in the programme"

words of Joni Mitchell: 'You don't know what you got til it's gone'. But I have patience and I can wait.

Meanwhile, I've been vaccinated and I'm encouraging everyone to go for it. The UK experience of Covid has been terrible by most objective standards. Our saving grace may just be our brilliant vaccine programme. Big shout out to anyone involved – so many people have stepped up to help run clinics and centres (*see In at the sharp end, page 25*). They are all making a bit of history.

So for the next couple of months, we have to be patient and find things to entertain ourselves (*see President's playlist*).

I feel privileged to have been asked to continue my HFMA presidency for a second year and hope that later in the year it may give me a chance to see some of you in person.

My theme of *Taking pride in our future* remains entirely relevant. All NHS staff can take pride in their response to the pandemic. The NHS is an amazing service and the actions of staff – on the front line and in support services – have only helped to underline why it is valued so highly by the public.

This year, the HFMA intends to explore two aspects of our future in particular. First, we want to look at how we harness digital technology to better meet the needs of our populations and patients. This is a massive and hugely exciting agenda, but we need to lay the groundwork so that we can realise the potential.

Finance staff have a big part to play in this programme – both in making the case for investment and helping clinical teams to identify opportunities for delivering value. We'll be working with Health Education England to raise awareness among the finance community.

We'll also be focusing on workforce issues, including how we can make further strides to improve diversity and inclusion in the finance function.

These are big topics and I'm excited about the chance to push ahead in both areas.

Contact the president on president@hfma.org.uk

"Lots of positives have come out of the simpler funding flows over the past year, including greater collaboration across systems"

disciplines will also need to be reimposed. Clinical teams have rightly been focused on frontline delivery. But cost improvement requirements are a fact of life and finance teams will have to re-engage, or step up their engagement, with operational colleagues – building on the enhanced relationships that have developed – to look for ways to reduce waste and enhance service value.

Tone and language will be all important. Targets need to service-specific and achievable. The focus needs to be waste reduction and value improvement.

Big agendas must be addressed. Covid-19 has further underlined problems with inequality across the country – both in access and in outcomes. There is a big appetite to address this among clinicians, and finance professionals should be major players in this (*see Making it real, page 30*). They can help teams to see opportunities, identify the best places to start and quantify the benefits of redesigning pathways – benefits that must be looked at across whole systems.

Finance teams have a lot to focus on in the immediate future, with the year-end and plans to be drawn up for 2021/22. But beyond those pressures, there is a huge agenda.

Financial discipline hasn't gone away over the past 12 months. There have been impressive governance and monitoring arrangements put in place often at very short notice. But many routine financial management processes will need to restart or increase in intensity alongside the recovery of NHS services. And the process of transformation – called for by the *NHS long-term plan* – will need to be kickstarted.

SHUTTERSTOCK

NHS England and NHS Improvement have raised the prospect of quarterly patient-level cost collections. We gauge opinion on what needs to happen to make more regular collections feasible

Collection

"One of the main issues is the time taken to produce the data, with the National Cost Collection (NCC) submission taking up to four months to produce.

The approved costing guidance needs to be simplified, as recommended by the HFMA Healthcare Costing for Value Institute proposal (hfma.to/mar211). The guidance should also be aimed at the minimum standards required to complete the NCC and quarterly collections, with additional sections showing the superior methodologies that trusts should look to achieve over time.

One area that particularly needs to be simplified is the general ledger to cost ledger mapping, which takes a large amount of time with little added value.

There is an opportunity cost in the increased time being spent on annual and quarterly national patient-level cost (PLICS) collections. It means less time is spent developing and reviewing PLICS data with clinicians and service managers, which will lead to a lowering of the quality of the data being produced.

The specialist

Chris Marshall, finance manager (costing), The Royal Marsden NHS FT

A specialist cancer care trust, its income is about £260m (2019/20). It made its first mandatory PLICS submission in summer 2019 covering 2018/19, although as a roadmap partner it made voluntary submissions from 2015/16.

At present, trusts have separate PLICS models for business-as-usual (BAU) and the NCC submission. Efforts should be made to bring BAU and NCC PLICS into line to avoid duplication of workload for costing practitioners. With the reduction in payment by results, perhaps we should consider removing costing of some or all unbundled activity, although this might require the development of additional healthcare resource groups to record the activity.

Trusts do not use the NCC output because it is not compatible with how BAU PLICS is reported internally. In addition, the NCC data is not published until nearly a year after the end of the financial year being reported and the data is relatively out of date. Published data also has low volume activity redacted, which makes it unusable for benchmarking.

Trusts pay the salaries of their costing teams, but an increase in time spent on NCCs will discourage them from investing in these teams, because it would not provide any benefit to the trust. If the centre wants quarterly PLICS for other purposes, it might consider contributing to the cost of local costing teams.

And finally, something needs to be done to reduce the impact of annual and quarterly PLICS collections on the recruitment and retention of costing practitioners.

This is already difficult, but will get worse if the role is just seen to be churning data for central demands."

"Costing requirements would need to be pared back and major improvements made in the activity data collected if the service was to move to quarterly cost submissions.

While in principle, more up-to-date costing data makes sense, the data produced and fed back continues to not be useful to providers, as we do not use the resource or activity coding in our internal presentation. And we also want the reporting to match to our ledger position.

In general, the guidance and coding requirements are too onerous to be accurately and consistently implemented. But for community services specifically, coding of activity remains inconsistent and we don't have a meaningful currency. So we know which service is delivering a patient contact, but very little about what interventions/therapies are actually being delivered.

As costing practitioners, we want to be working with services to help them improve patient services. As they are currently formatted, the NCC submissions take us away from that work. They are time-consuming and they require separate costing models to be run from the ones that produce the data we use internally.

The mental health/community services provider

Alex Packard, finance manager, Berkshire Healthcare NHS FT

With mental health and community income equally split, the trust made its first mandatory PLICS submission recently, covering 2019/20, and is due to submit community costs in 2022.

The biggest difference is the NCC requires us to cost admitted care using spells, while for our internal data, we cost this as single days, which we believe to be much more useful.

There also needs to be more testing with practitioners. Currently, the validations tool is too rigid. This needs to be relaxed, with the guidance then refined based on what is submitted, or they need to work with some trusts to test the rules in advance.

For collections to be quarterly, the centre needs to move much closer to collecting what trusts produce for local use.

The trust submitted patient-level costs for mental health services as part of the 2019/20 submission. This took a significant amount of team resource to produce a submission that would be accepted by the data validation tool (DVT). We had to make changes to our internal costing model and adjust coding in the cost ledger.

There was also a lot of time lost on model recalculations as a result of DVT errors and costing system bugs. These have arisen because of the speed with which they are being expected to update systems in order to reflect guidance."

for all seasons

Back-office functions have changed as a result of the pandemic and this includes cost accountants. Instead of submitting returns to support tariff development and the Model Hospital, they are supporting clinicians.

Armed with continuously improving patient-level data, the cost accountant's work is increasingly focused on helping to identify waste and ensuring resources are used to best effect to meet patients' needs. The growth of waiting lists and the need to maximise the available resources to reduce this backlog make this even more important.

In this context, it may seem counterintuitive to ask teams to 'feed the beast' of NCC every quarter, a task many struggle to complete annually. The issues are complex, but simpler solutions have worked. We should consider:

- Nottingham developed the Wave programme using detailed analysis of patient-level data to support clinicians. Clinical heads of service and the board want additional time targeted at this programme to help achieve recovery targets. Central costing return demands, which eat into cost accountants' time, cannot come at the expense of this programme.
- While the exceptional quarterly collection is not onerous, it provides only modest insights as it is not at patient level. Previously, 93 trusts contributed to a patient cost benchmark club, which required a straightforward patient-level return, with modest levels of detail. Most importantly, it provided regular, meaningful reports used by clinicians.
- The NHS needs the higher quality, more granular information promised by the NCC. The pilot programme demonstrated that 68 trusts could deliver this detail for every healthcare resource group. However, we have since learned that:
  - Not all trusts have software up to the task of supporting this more detailed information.
  - Not all costing teams have the experience and expertise to deliver the extensive unbundling, mapping and interpretation necessary to provide a meaningful return.
  - Different organisations use different methods to convert their local cost data into NCC format leading to inconsistency and making the NCC data less suitable for use in benchmarking.

Other countries use different approaches to supply the necessary information to meet national uses. Germany, for example, provides funding for a selection of providers, operating to best practice costing standards, to meet more than minimum standards on granularity. NHSE could combine this with a more straightforward return for all.

Up-to-date patient-level data should provide valuable insights for our clinicians to improve patient care, more rapidly recover from the pandemic, and minimise the effects of delay-related patient harm. Clearly, we must support it, but we need to find a practical way to achieve the vision.

The acute trust

Duncan Orme, operational director of finance, Nottingham University Hospitals NHST

One of the largest teaching hospitals in England, it implemented a patient-level costing system in 2010 and made its first mandatory submission in summer 2019 covering costs for 2018/19.

We understand and support why NHS England and NHS Improvement want to collect patient-level cost data more frequently. But several issues need to be taken into account. First, the detail and specifications will be crucial. Each provider has its own different patient-level cost model for BAU use, and running an output for the quarterly return, which mirrors NCC requirements. This means a significantly different model must be processed and submitted – there is no simple 'extract data and submit' button. New requirements to include specialist ward care details would extend further the gap between BAU and submissions.

As well as the time taken, there is a value consideration for local providers. Other than complying with the regulator, will further submissions be at the expense of the BAU models? Costing teams would find it difficult to run and maintain two very different outputs for different audiences simultaneously.

Providers that only cost quarterly may find they are working full time to create submissions for the NCC, involving contributions from IT, informatics and other colleagues. Inevitably, the work needed to provide high-quality costing output for their own organisation may become a lower priority.

Morale of this under-resourced area of the sector is also likely to be affected by having to provide more submissions each year on top of current workloads. There is also a capacity challenge, with many costing teams struggling to carry out business-as-usual work for their provider as team members are redeployed for the pandemic response. Home working has also created difficulties for some teams.

Unless a quarterly collection can be simplified to fall naturally out of a provider's BAU models, it will be an unpopular collection due to the additional burden on costing teams and the value being potentially diluted.

The supplier

Peter Lane, Lead for IQVIA UK&I Healthcare

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Mi Healthcare 25 years

Digital future

NHS finance does not widely use automation and artificial intelligence, but interest is growing to remove repetitive tasks and increase the efficiency of everyday processing jobs. A recent HFMA roundtable heard how automation could benefit the NHS and the steps needed to embed it in finance departments. Seamus Ward reports

HFMA ROUND TABLE

NHS finance can be a fulfilling place to work – helping clinicians to deliver the best outcomes for patients. But, as with most jobs, there are repetitive tasks, mainly transactional tasks, that also need to be done. Ensuring suppliers are paid – and paid the correct amount – for example, is vital to the financial buoyancy of any organisation. But the modern NHS needs these tasks to be done quickly, accurately and efficiently – outcomes that lie firmly in the domain of robotic automation.

A recent virtual HFMA roundtable, *Is automation the way forward for the NHS?*, sponsored by NHS Shared Business Services (NHS SBS), discussed the benefits of the technologies and the barriers to their introduction. While automation is not new to the NHS, and is used routinely in some finance departments, the roundtable heard that it was not deeply embedded in NHS finance

Chairing the event, Ian Moston, chief finance officer of Greater Manchester hospitals group the Northern Care Alliance, said the NHS had much to gain from automation. 'If we get this right, there are considerable opportunities to redirect resources to where they make a bigger contribution to patient care,' he told the roundtable.

Stephen Sutcliffe, NHS SBS director of finance and accounting, said he believed the technology was game-changing for the accountancy profession in the NHS. In its implementation of robotic process automation (RPA) – software that can replace repetitive and rules-based activity – NHS SBS has more than 100 software robots automating 250 processes, and saving 500,000 working hours a year. 'It's not as easy as some of the vendors will tell you it is, but it is worthwhile,' said Mr Sutcliffe. The NHS has many processes, both clinical and back-office, he added, and technology could help efficiency in these areas.

Mr Sutcliffe's NHS SBS colleague, Mathieu Webster, who is transformation lead for finance and accounting, said RPA aids connectivity. In an individual NHS finance function, automating the connections between enterprise resource planning and the electronic staff record is a relatively simple place to start, he said.

Leadership role

However, finance had a more fundamental role to play in leading automation in the NHS. 'From a finance function, the starting place is to show some leadership,' he said. 'How can you ask the rest of your organisation to automate if you are still doing everything manually?'

Mr Webster said there were still some NHS organisations not using RPA. 'We are not fast followers in NHS finance. In workshops we've had with some of our NHS partners, they don't understand what the problem statement is. They see processes and they see things happening, and they just accept that's the way we work. If we as leaders can educate them, that's the first step; otherwise, we will never be fast followers.'

Management consultant Rakesh Sangani, chief executive of consultancy Proservartner, said automation was essential. 'If you are not leveraging some form of automation – for example, for invoice processing, cash applications and bank reconciliations – you should be asking yourself why,' he said. 'In terms of what other NHS entities are

doing, never mind what industries are doing, you are probably behind the curve. This is almost table stakes to get the credibility internally to do some of the stuff where you are providing value to the clinicians.

'If you started a new hospital tomorrow, would you set up the finance function the way you have today? Would you not have processes a little bit more streamlined – with a lot more automation – and have your finance people providing more business partner roles into the rest of the organisation.'

Taking the initiative

The roundtable heard examples of how trusts have adopted automating technologies to release staff time for more value-adding work.

Phil Bradley, Northampton General Hospital NHS Trust's director of finance, said the trust had just been appointed an RPA hub and had been given funding to develop it, and to share with other NHS providers.

A new head of emerging technology had developed a number of bots, he said. 'The first one he developed was during Covid and it was a bot to take the readings from oxygen tanks. At the start of Covid, we had to have someone from the estates team take readings every hour throughout the day and night. This little bot did that automatically.'

Mr Bradley is working with the finance team on areas such as matching purchase orders and invoices, but also more complex processes such as those between HR and payroll.

Claire Liddy, managing director of innovation at Alder Hey Children's NHS Foundation Trust, is leading the trust's programme to bring new technologies into healthcare, but has spent 20 years in NHS finance. Alder Hey's innovation centre is the site of its artificial intelligence headquarters, which includes the trust's RPA centre of excellence, data science and machine learning.

'Everything we do in innovation needs to have an impact on the way we care for patients and benefit patients,' said Ms Liddy. 'In our early wins, we started with some of the back-office functions such as finance, purchase orders, invoice payment and HR recruitment forms. We've also started to focus on clinical needs, because we see RPA – in terms of how it benefits patients – has taken some of the admin burden away from clinicians so they can focus more on caring for patients.'

The trust has been working on RPA in the referrals process, on transcription, and even scoping some frontline services, such as safe waiting list management. 'The opportunities are almost unlimited. I see RPA as one tool in a package of technology solutions that we really should be harnessing in the NHS to optimise healthcare. As a finance community we have a role to play in terms of how we get the investment into these new technologies.'

Mr Moston added that booking and scheduling were ripe for using RPA. 'It will take some of the steps out that are uninteresting to staff, but it's also an area that, if we get it wrong, can have terrible consequences for patients. Getting it right nearer to 100% of the time with an automated process will have huge significance for the patient experience.'

Daniel Haigh, deputy director of finance at NHSX, said automated interrogation of the unwarranted variation in finance systems, using integrated patient costing analytics and Scan4Safety data, was likely to have the greatest benefit for patients.

He added: 'This can help to reduce costs, but also increase the quality of care we deliver to patients. I think we can also drive the value-add accounting of RPA, and automating some of the accounting processes can divert more time to looking at the value-add activities. How can we procure our goods and services more effectively, more efficiently and at a better price?'

Integrating finance systems with operational business intelligence systems would improve forecasting accuracy and allow faster planning, ensuring budget holders get the information in a timely manner, Mr Haigh added.

The discussion moved on to how and when to automate. Adrian Snarr, director of financial control at NHS England and NHS Improvement, said that although he was an advocate for automation, he felt the finance community needed to take a step back.

'If you're not careful, the technology entices you in and you have to keep reminding yourself of the problem that you're trying to solve,' said Mr Snarr. 'If we truly want to embrace technology and automation, we're going to have to be realistic. The NHS is not very good at standardisation – NHS organisations do their own thing, by and large. If we're going to maximise the use of technology, we're going to have to look at where it's scalable.'

For example, NHS SBS has been working on an RPA solution for NHS England's control accounts. 'We set them a double challenge – can you make an RPA solution work, and can you make it scalable so that we could quickly send it out across ISFE [integrated single finance system] to commissioning organisations.'

Guy Kirkwood, chief evangelist at RPA specialist UiPath, said scalability was critical. RPA only works if it's available across the entire business, including the finance operation, he insisted.

Research has demonstrated the importance of employee engagement to an organisation's success, he added. 'What drives employee engagement isn't to do with how much they are paid, it isn't to do with how much they are praised and so on – it's all to do with the individual believing that the work they do is driving the business forward and achieving what they think, as individuals, is important. The more you can reduce the boring, repetitive work, the better the employee engagement.'

Mr Kirkwood said 80% of automation programmes were tactical

Participants

- Phil Bradley, Northampton General Hospital NHS Trust
- Daniel Haigh, NHSX
- Guy Kirkwood, UiPath
- Claire Liddy, Alder Hey Children's NHS Foundation Trust
- Ian Moston (chair), Salford Royal NHS Foundation Trust
- Lee Outhwaite, Chesterfield Royal Hospital NHS FT
- Rakesh Sangani, Proservartner
- Adrian Snarr, NHS England and NHS Improvement
- Stephen Sutcliffe, NHS Shared Business Services
- Annette Walker, Bolton NHS Foundation Trust
- Mathieu Webster, NHS Shared Business Services

"For the past 30 years, finance and innovation have probably been like oil and water. My challenge to the HFMA is: how do we make finance the futurist?"

Claire Liddy, Alder Hey Children's NHS FT

Centre: Ian Moston, chair
Clockwise from top left: Phil Bradley, Guy Kirkwood, Mathieu Webster, Stephen Sutcliffe, Daniel Haigh, Claire Liddy, Lee Outhwaite, Adrian Snarr

– simply mimicking work that was already being done, though more efficiently. 'For 2021, we need to focus on triaging and re-engineering the organisation as a whole,' he said.

'Ask for help,' he added. 'As you go through the process of building and scaling your operations, then ask us, the vendors and your support structures, and indeed NHS SBS.'

Removing unnecessary processes

NHS organisations must examine whether processes are necessary before automating them. Mr Sangani said: 'There's nothing more inefficient than to automate something you could have eliminated.'

Mr Snarr agreed. Referring to an NHS England project with Future-Focused Finance, NHS SBS and trust colleagues, he said: 'One of the mantras we have set ourselves is whether the transaction is necessary. And if it's not necessary, eliminate the transaction before you have a conversation about the automation.

'We've spent a lot of time talking about non-contract activity, which is the invoice volume that drives low-value transactions in the NHS. We eliminated that at a stroke at the beginning of Covid and there hasn't been any adverse impact. I think we will find a way through to make that a substantive change.'

Many believe that for technology to deliver change in the NHS, it has to be cutting edge, added Mr Snarr, but there are benefits to be gained from older tech – 50% of clinical commissioning groups do not use electronic invoicing, for example. 'We have a lot of basic things to do that people might not consider technologically advanced.'

There was some feeling that the number of organisations in the NHS created a barrier to the use of automation – fewer organisations would reduce transactions and allow scaling up of the technology and standardisation.

Mr Moston asked if the finance function had to find a way to produce business cases in support of the new technologies, especially in clinical areas. 'Once you get out of some of the smaller processes – and in relative terms, our corporate processes are some of the smaller processes – and take this into the forward-facing space, the introductory costs are huge. This may be partly answered by the need for scale, the need to standardise and potentially the number of organisations.'

NHSX's Mr Haigh acknowledged it was sometimes difficult to show the benefits of deploying technologies up front, especially when the products or services are new.

'There isn't a tried and tested model to test against, and that's something NHSX is looking at. How do we create a set of blueprints – digital exemplars that we can share around the system that people can build compelling business cases from, and understand the benefits that other providers of similar size and set-up have been able to achieve from deploying new technologies.'

NHSX is looking at outcomes from investment as a way of building the business cases, he added. 'We know the outcome we want to achieve, and we know from experience it will cost in the region of x amount of money. So, how do we write a compelling business case that might not have all the information usually expected, but underpin that with a strong, agile delivery mechanism with the correct milestones and gateways in to access funding accordingly?'

Benefits realisation can take up to five years for a large-scale technological transformation deployment. NHSX is trying to build the blueprints to enable business cases to be more compelling, together with the roadmaps that allow benefits to be accessed more quickly, Mr Haigh added. The organisation is also providing matched funding through its provider digitisation programme to help implementation.

HFMA ROUND TABLE

Annette Walker, director of finance at Bolton NHS Foundation Trust, said she has been cautious about artificial intelligence and RPA, but had recently been leading an internal programme looking into the technologies, the opportunities they presented, and what had been implemented at the trust already.

Members of her finance team, along with other departments in the trust, are looking to develop business cases to invest in technologies and there is a lot of enthusiasm to explore the potential benefits.

However, she pointed to implications that do need to be thought through – the social value of replacing people with robots, for example. 'Is that the right thing to do for our employees? I struggle with that.'

Other delegates said new jobs were coming into the NHS. A whole new workforce was needed, with new careers and opportunities. Speakers said some roles such as RPA developer were difficult to fill, but the NHS was recruiting and training its own.

The point of automation was to deliver money back to frontline care, Mr Sutcliffe said, and even when headcount went down, as it has in the past at NHS SBS, this could be achieved while maintaining staff morale.

Mr Sangani said the biggest barrier to adoption of technologies such as RPA was passive resistance. 'I think you need to think through your change management and communication, even when you're doing a pilot, in terms of what it means for people's jobs. People on the ground will be wondering what it means for them.

'It's these people who will help you make this a success or failure and, for me, the biggest barrier is winning hearts and minds.'

There were opportunities across finance – order to cash, procure to pay, order to report – that would generate efficiencies, reduce errors and improve outcomes, he added.

Finance had a key role in showing where the new technologies could help the organisation Mr Bradley said. 'The biggest stumbling block to taking these things forward is culture and people's willingness to change. Where automating a particular process can take a post out, we don't just continually revert to moving the individual on to somewhere else. We actually start looking at how this can actually help us achieve the efficiency and productivity in the savings we require year-on- year.'

Lee Outhwaite, director of finance and contracting at Chesterfield Royal Hospital NHS Foundation Trust, and finance lead of Derbyshire

integrated care system (ICS), said the finance function, together with other admin functions, would look 'seismically different' in the future, tilting away from transactional processing and towards roles such as business partnering and informatics.

He asked to what extent finance professionals were discussing technology to deliver improved, integrated and better care – and whether the finance community should even be discussing this. He believed it should – but were finance staff willing to have a separate discussion about back-office services and how processes could be delivered faster and more efficiently?

'I'm a bit more interested in the conversation that leads us in the direction of technology adoption to lead to self-care and channel shift away from high-cost areas of treatments – and how we do that more proactively,' said Mr Outhwaite.

'I'm more interested in that than getting drawn into a conversation on how we consolidate our chart of accounts, or to what extent could we use robotic process automation for paying invoices.

"I'm not saying these are unimportant – they are entirely helpful things. But as finance people, I would hope we are a bit keener on the adjunctive technology to deliver taxpayer and patient value, and what that looks like.'

Integrated care systems

Speaking before the government white paper on NHS reform, delegates added that the advent of ICSs opened up opportunities to introduce automation. Mr Bradley said a lot depended on the duties given to ICSs. 'Are they going to be old district health authorities with FHSAs built in? What are provider collaboratives going to be? Will they be separate entities? If we are going to be coterminous within a particular geography, we need to look at a standardisation approach. The end game will help some of the decision-making going forward.'

Ms Liddy warned that ICSs may not be the prompt for a fast implementation of standardisation. 'We have talked for some time now about corporate services collaboration and standardisation across systems. There have been many collaboration vehicles that have talked for years about ledgers, chart of accounts and standardisation, but progress has been mixed and the conversation continues. We have to make a move now on RPA.'

Mr Outhwaite said the finance function may need disruptive innovation to make it more agile. 'I think there's something about the ICSs becoming a statutory organisation as a catalyst for change in the back office that I would grab with both hands. However, what is the new technology that will enable us to do different things around care integration and personally empowered care?

'ICSs have two dimensions – are they the disruptive innovation that will give us a different way of running things? If I walk into my finance function, it does broadly similar things to the finance function I walked into at the start of my career in 1993. I'm not persuaded most finance functions have moved on that fundamentally. The other dimension is about how we do health and wellbeing, as a service, beyond the traditional NHS role around curing disease.'

"If you started a new hospital tomorrow, would you set up the finance function the way you have today? Would you not have processes a little bit more streamlined"

Rakesh Sangani, Proservartner

"There's going to have to be permission for finance directors to be more risk-takers. How we do that may be a challenge"

Annette Walker, Bolton NHS Foundation Trust

A change in NHS finance culture could be needed to move automation into the mainstream. 'As a finance function, we need to be more futurist in our thinking,' Ms Liddy said. 'If we are really serious about making the NHS balance its books, be sustainable and deliver high-quality care for the benefit of patients, the finance function has a role to play in thinking differently.

'At Alder Hey innovation centre, we don't think as much about annual budget cycles, we think five years out. We should be thinking now about what technologies are going to break through, delivering impact. We should be working collaboratively and co-creating with industry to help bring new technologies in that benefit hospitals and systems.

'These disruptive innovations will probably save the NHS money and will probably deliver better patient care – for example, by reducing harm. If you can do that in a commercial way, there's revenue back into the hospital in terms of licences and royalties to fund these new technologies. For the past 30 years, finance and innovation have probably been like oil and water. My challenge to the HFMA is: how do we make finance the futurist?'

HFMA ROUND TABLE

Ms Walker said finance directors had been conditioned into thinking about value for money from investments, productivity gains and living within control totals. A change in mindset may be needed to start thinking over a five-year period, take more risks, and make the most of automation and new technologies.

'It's alien to us not to have every bit of a business case buttoned down before it's signed off. But unless we get into that headspace, I don't think we're going to change anything. We've got to take quite a big risk – we saw it in Covid where we did it at scale and we got the benefits. I think there's going to have to be permission for finance directors to be more risk-takers with some of the propositions we see. How we do that as a profession may well be a challenge.'

Mr Moston said the profession had to be prepared to fail. 'The technology is such that we won't get every deployment right. How we can afford the failure is a key part of this. Some of that comes back to the earlier points on scale and the number and size of organisations needed to be able to take a risk.'

Finance should act as a role model, Mr Bradley said. 'We've got to embrace this and get on with it to show the benefits. We have to win hearts and minds. And we've got to think outside our silos – how can this help the system? At the end of the day, we've got to ask how this is benefiting the patient, to have that as a backstop for anything we do.'

There were concerns about automation's potential effect on staff, and the need for the NHS finance function to be clear what it is automating and why, but in general the roundtable delegates agreed that there were benefits in moving the focus to value-adding work in finance, operational and clinical areas. This would ultimately benefit patients.

A new workforce

Software robots employed in automation and artificial intelligence present significant opportunities for the NHS in terms of efficiency and efficacy. Seamus Ward speaks to trusts that are reaping the benefits

As the pandemic, we all hope, recedes and normal NHS service is resumed, the language of cost improvement, waste reduction, unwarranted variation and efficient theatres will return. After years of productivity and efficiency gains, the service will feel that it has grasped most of the biggest opportunities, but – as noted in the recent HFMA roundtable (see p13) – automation and artificial intelligence (AI) could open new avenues to improve efficiency and quality, including NHS finance.

The NHS in England has a strategy, as part of its long-term plan, that aims to make the service a world leader in AI and machine learning. The thrust of the strategy is the use of software to free up staff time across the NHS, at the frontline and in support services.

AI refers to software that can emulate, to some extent, human reasoning or analysis – for example, the algorithm used by TV streaming services to suggest shows or films you might like based on your previous viewing.

Automation, or robotic process automation, refers to the ability of computer programmes to perform enormous amounts of repetitive tasks accurately.

Automation gurus see the software as a workforce of software robots who never get tired and can repeat monotonous tasks with a high degree of accuracy every time. Trusts are, for example, using automation software to cancel appointments when requested by patients, and notify the clinic of a free appointment slot that can be reallocated.

Not only is this a better use of clinical time, but also delivers significant savings to providers. Automation and AI can be combined to analyse a lot of tests quickly, and produce accurate diagnoses.

Finance departments in some trusts are making strides in automation and AI. East Lancashire Hospitals NHS Trust's automation of its finance processes led to it winning the HFMA Embracing Technology Award 2020. Not only do its systems pull the latest figures from a master database into files automatically, but software also helps analyse thousands of lines of costs.

The work was prompted by a familiar requirement. Finance departments must be as efficient as possible, but they tend to

Robot workers

Digital workers – software robots or bots – can free up staff time and can help make IT systems interoperable, according to a recent HFMA briefing with Blue Prism.

A digital workforce must be part of any organisation's digital armoury, and automation should be backed at strategic level if it is to make an organisation-wide impact, it said.

The briefing is based on research looking at whether technology and digital developments are part of NHS boards' strategic thinking. The research found that board papers raised technological transformation and the wider use of digital solutions, but there was little evidence of discussion on how digital strategies would be achieved, or review of metrics or key performance indicators. And, while most NHS bodies had staff digital champions, individual staff were often unaware of what the digital agenda meant for them.

The HFMA and Blue Prism, a leader in automation across the world, found examples of good practice in the NHS:

- The **Royal Free London NHS Foundation Trust** is developing a project to use digital workers to gather usable outpatient clinic data. There is limited data about the clinics currently, partly because of the payment system, which means detailed coding is not required. Rather than adding an extra task for clinicians by asking them to record a diagnosis in the patient record, the use of digital workers is being proposed. Following clinics, letters are written to the patients and their GPs that include the diagnosis – digital workers could 'read' the letters and record the diagnoses.
- The **Royal Marsden NHS Foundation Trust** is using a software robot to process agency invoices. Currently, HR staff validate invoices manually against the staff rostering system, and capture the cost centre to be added to the trust's accounting information. In the new process, a bot will validate invoices, add the information to the accounting system and present the invoice for approval and payment by a member of staff.

• The briefing can be downloaded from **www.hfma.org.uk/publications**

"We will be asking what other services we can provide. People will be engaging with the business owners in the trust and adding value"
Darrell Tobin, East Lancashire Hospitals NHST

accumulate tasks that do not add value, says Darrell Tobin, the Lancashire trust's costing consultant, who has masterminded much of its automation work.

Technology and computing offer a way of addressing this, but the NHS does not use these tools as much as it could, and certainly not as much as the private sector, he adds.

The trust has automated some of its analysis work through its Fast (Forecast Analysis Statistical Tool) software.

Focus areas

One of the first areas Mr Tobin looked at was the month-end process and the comparison of costs at each cost centre. 'We look for unusual movement – for example, where spending is up by more than 50%, or dropped by a significant amount. And then we see if that is acceptable or unacceptable. Historically, we have been checking every line manually, and this was something we could automate,' he says.

'In addition, using their own personal knowledge, staff were checking certain cost centre items because they had seen movements in the past. That was not particularly efficient – they were checking 90% of the codes every month, when they hadn't moved up or down by 10% or less.'

The trust used standard deviation to come up with statistical measures of movement. This assessed whether a change was statistically unusual or part of a normal distribution.

Kathy Mortimer, a financial adviser at the trust, says the software highlights areas that require further investigation. Indeed, the trust says finance staff need only check 20% of line items regularly.

'We can check if the lines highlighted are correct – was it a miscoding, for example – but overall, it reduces the workload for the finance team.'

She adds that the software has led to greater quality and accuracy.

The finance team can place comments against each highlighted line, which feed back into the software's learning database about what constitutes an adverse movement.

Mr Tobin is building a directory of common statements to be used to indicate whether a movement is acceptable or unacceptable.

The availability of these comments to all appropriate members of staff gives a degree of organisational memory – ensuring the finance team can compensate for annual leave and illness, or if a member of staff moves on.

Mr Tobin adds that the team will not need to check every cost centre code each month – those with little to no significant movement could be checked quarterly or even every six months.

Because it is statistically driven, the software works well with large or small items of spending. 'Once an item is flagged as unusual, finance colleagues can put comments in,' Mr Tobin says. 'When they do this, the system stores these comments and the following month – or immediately dependent upon settings – the comments are presented back, attached to the cost centre account code line item. This eliminates duplicated checks on line items.'

This access to the information, and its movement between different systems across the trust, is facilitated by a piece of automation software known as Petals or Programmable Extract Transform And Loading System. The trust has one large database from which up-to-date figures can be pulled into, for example, the Fast system, Power BI or its ledger automatically.

This means finance and procurement staff, business managers and others are working with the latest information

'The idea, over time, is to create a network of these databases across trusts. If you standardise and align the ledger databases and then standardise the ledger with data and metrics, you can challenge suppliers on the cost of an item to see if you are getting value for money,' Mr Tobin says.

As the NHS recovers and renews its attention on reducing waste and unwarranted variation, he believes the system will help release significant savings, and staff time will be released and recycled.

'We will have extra time because we are not wasting it on non-value-added tasks. We will be asking what other services we can provide. People will be engaging with the business owners in the trust and adding value.'

The automated identification of cost savings was the focus of a recent pilot run by software developer Civica. It says that across the six trusts in the pilot, potential cost savings opportunities of at least 3% were found in each trust in under 24 hours.

The software, called Aurum, examines patient-level costing data to find systemic variation in clinical activity that might otherwise be missed, and found savings totalling £40m in the pilot sites.

Steve Haines, managing director for Civica Population Health Intelligence, says costing can generate huge amounts of valuable information, but it is underused.

The software focuses efforts on opportunities to drive value and identifies variations in activity at a clinician and system level – a surgeon who spends longer performing the same procedure as colleagues, or theatre capacity consistently under-used.

Software pilot

North West Anglia NHS Foundation Trust was one of those involved in the pilot. Taking 2019/20 data from Civica's CostMaster software, which provides the trust with patient-level costing, service-line reporting and end-to-end cost management, Aurum found potential savings worth £10m.

The software identified opportunities to maximise theatre capacity, which will be increasingly important as the NHS seeks to return services to pre-Covid levels, hopefully later this year.

Joel Harrison, the chief finance officer at North West Anglia NHS Foundation Trust, says Aurum will play a critical role in supporting the trust's long-term financial sustainability, helping to increase productivity and the overall quality of care.

The trust has used service line reporting information on a quarterly basis for several years. 'This was analysed at a divisional and service level. However, the pilot presents us with an opportunity to look at our information and activities in a much greater level of detail,' he adds.

'It's really important we use all our resources efficiently; this tool will enable us to focus resources on areas of greatest opportunity. It brings these to life and allows the teams to spend time on delving into the detail rather than trying to understand the data.'

The Aurum system has enabled the trust to identify and focus resources on the areas that appear to have the greatest opportunity for productivity or efficiency gains, and identify opportunities for variation within services and at a consultant level.

"The pilot presents us with an opportunity to look at our information and activities in much greater detail"
Joel Harrison, North West Anglia NHS FT

Understandably, cost improvement is not the focus for trusts as they continue to address the challenges presented by Covid-19. But Mr Harrison says the trust will benefit from the savings opportunities identified by the system.

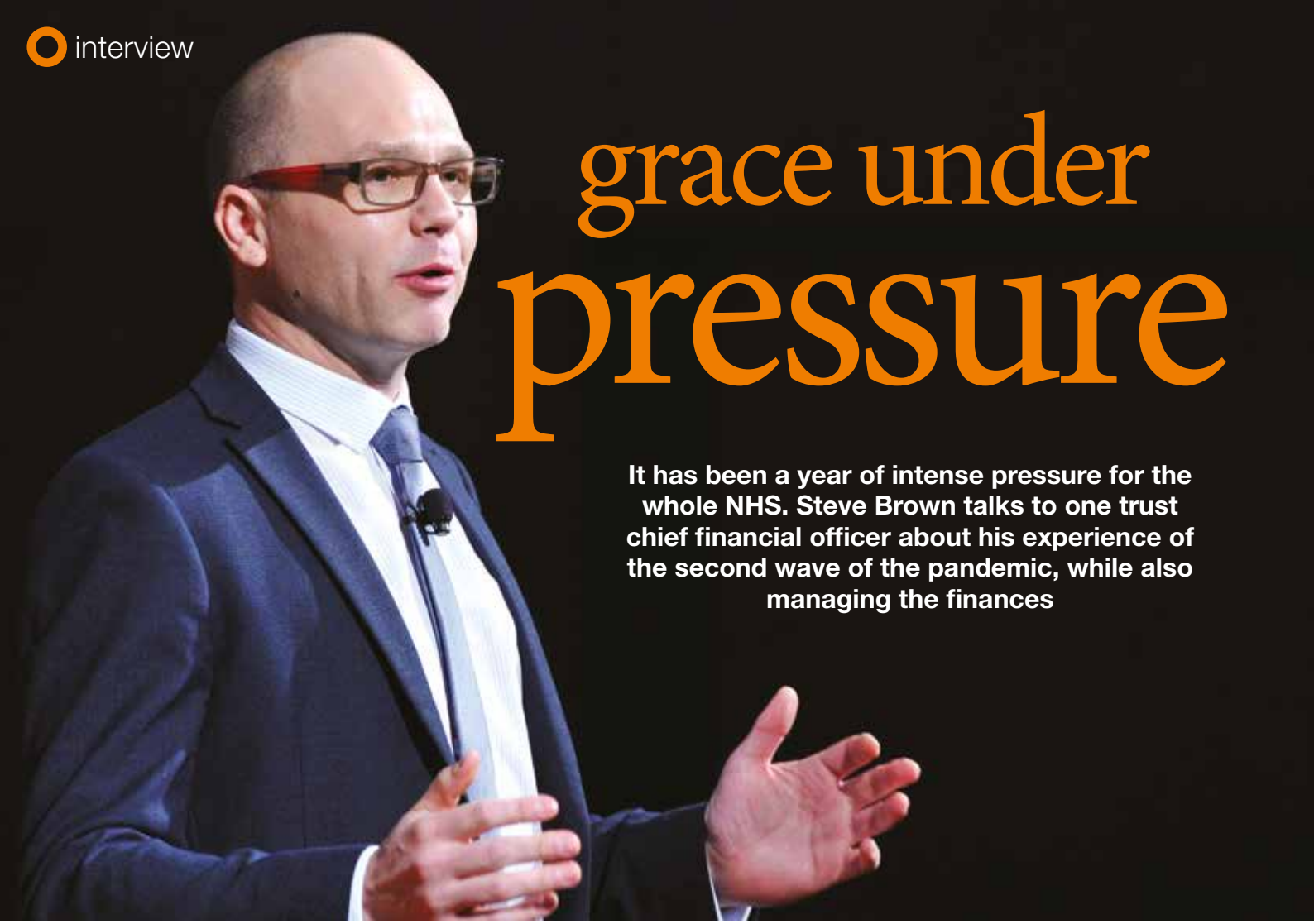
'Given the pandemic, we've had limited opportunity so far to really explore the benefits of the tool and particularly socialise it with our clinical teams,' he says.

'We're looking forward to building on our initial analysis and embedding the tool into our developing transformation programme; working alongside our clinical teams and in the longer term as part of our increasing integration of services with our system, primary and community care partners.'

There is no doubting the power of automation and AI. The latter has been used at national level to aid the NHS response to Covid-19 by tracking patterns and markers of the illness.

Automation offers a relief from the monotony of some repetitive processes, but also gains from higher accuracy and faster processing. AI could help trusts dive deeper into the data, finding otherwise invisible savings opportunities.

The NHS may be fully focused on dealing with Covid, but automation and AI could be vital in its recovery.



grace under pressure

It has been a year of intense pressure for the whole NHS. Steve Brown talks to one trust chief financial officer about his experience of the second wave of the pandemic, while also managing the finances

One day stands out. Portsmouth Hospitals University NHS Trust has had a year like no other – along with hospitals across the country – as it responded to the Covid-19 pandemic. But for Mark Orchard, the trust's chief financial officer, Saturday 2 January is particularly memorable. 'It was the most operationally demanding day of my career,' he says.

Portsmouth is a big acute trust with some 8,000 staff and 1,200 beds, nearly half of which were filled with Covid-positive patients at the height of the second wave of the pandemic at the beginning of the year.

The city had become something of a hotspot for the virus, with infection rates well above the national average, and this had increased the pressure on acute services rapidly. The nearly 40 intensive care unit beds occupied were less than the peak of 59 that would be reached later in the month, but nearly double the trust's normal capacity.

On 2 January, Mr Orchard was the trust's gold command executive on call and the numbers of Covid patients presenting at the hospital were beyond the levels that had to this point reliably been predicted by the modelling.

'The pressure was intense, and the numbers were growing,' he says. He spent more than 15 hours on site and, while the day was full of incident and decisions that needed to be taken, he remembers one challenge in particular from an extremely busy 24 hours.

'Three out of four patients who were presenting were already Covid-positive and that put a lot of pressure on our front door and on our red pathway,' he says. 'We had empty beds becoming available, but we couldn't turn them around quickly enough – despite deploying extra scrub teams. We were also short of staff and couldn't open up our internal surge and escalation capacity.'

> **"We had empty beds becoming available, but we couldn't turn them around quickly enough – despite deploying extra scrub teams"**
>
> **Mark Orchard, Portsmouth Hospitals University NHS Trust**

The ambulance trust was also experiencing huge demand and, in a series of escalation calls, it was pressing to be able to hand over patients and get its vehicles back on the road.

The trust had the space to take patients off the ambulances more quickly, but not the staff. So, the suggestion was made to open up the trust's surge capacity to take six ambulances' worth of patients, manned by one ambulance crew and overseen by one senior nurse.

It was not a new idea. 'This had been mooted by the ambulance trust over the years for times of extreme pressure, but it had never been agreed,' says Mr Orchard. However, in the space of a few hours, the new arrangement was put in place, involving agreement with the trust medical director and emergency department consultant and negotiation with the ambulance trust.

It was a good solution, rapidly put into action, and it created some much needed breathing space for the emergency team, while releasing ambulance crews back to the streets. But it was not enough to relieve the pressure.

More was needed. The trust's silver command managers were getting increasingly vocal in calls for an opportunity to reset by diverting ambulances for a period to a neighbouring trust. Mr Orchard says, in his experience, this is difficult to put in place at any time. But during a pandemic, when the whole country is facing sustained pressure, it becomes even more challenging.

The trust's nearest neighbour – University Hospital Southampton NHS Foundation Trust – was faced with its own significant pressures and was unable to help. However, Hampshire Hospitals NHS Foundation Trust, which has hospitals in Winchester and Basingstoke, indicated it might be able to do something.

Coming through the storm: Portsmouth Hospitals University NHS Trust

Putting this into action took a further two hours of discussion and checks, plus a group call involving the ambulance trust, the Winchester and Basingstoke site directors and their trust's executive on call. 'So you end up with eight or nine people on a call to agree the parameters around this ambulance divert,' Mr Orchard remembers.

'It was about four o'clock in the afternoon at this point and we agreed that all our trauma activity would go to Basingstoke and all of our confirmed Covid-negative patients would go to Winchester for a period that would be under review, but would likely last until 10pm,' he says. 'This was later extended until the following morning.

'Of course, this meant a greater proportion of our patients were Covid-positive, but it gave us the breathing space we needed and allowed us to focus on them.'

He says both the ambulance trust and Portsmouth's acute neighbour were brilliant on the day and it is a great example of how working across the system has been enhanced during the pandemic – something the trust is committed to as part of its *Working together* five-year strategy.

Pressure has subsequently reduced across the country since the January peak, and Portsmouth is no different. By mid-February, it was treating 255 patients with a Covid-19 diagnosis. While this was still above its peak level in spring last year, it represents a 50% reduction on its more recent January peak. And the rate of infection in the community is also heading in the right direction.

For the trust, this means the focus can return to the reintroduction of services that had to be paused. Waiting lists have grown across the country as non-Covid capacity has decreased and there are likely to be further increases in list sizes as pent-up demand finally turns into referrals. Mr Orchard says the trust is now working on how it can return to more of its normal levels of activity, although he acknowledges that full recovery for the NHS will be measured in years not months.

Staff are also a major consideration in the return to more normal service delivery alongside reducing Covid activity. He pays tribute to the efforts made by all the trust's staff in getting to this point and recognises that it is not realistic to expect them to continue to work at the same levels of intensity, whether that is on Covid or recovery work.

'We know that many of our staff have been working in difficult and often unusual situations to their usual work or even place of work,' he says. 'So our recovery plans will be carefully balanced against the need for everyone to take time off and rest. Their wellbeing is incredibly important to us and we will do everything we can to ensure this is done in a balanced and sensible way.'

Mr Orchard has spent a lot of time focused on Covid-related issues during the year. Not only was he part of the gold command executive team, but he spent more than six months as the trust's emergency accountable officer, ahead of the appointment of a new substantive chief operating officer. And more recently, he was executive lead for staff testing, overseeing the roll-out of lateral flow testing for asymptomatic staff. But the chief finance role remains vital.

Financial recovery

The trust has made significant strides forward financially over recent years, and Mr Orchard is determined to keep up the momentum. It broke even in 2019/20 – in fact, recording a small surplus – after years of deficits, culminating in a deficit of nearly £38m in 2018/19. The 2019/20 break-even position was achieved with national support of £17.5m through the Provider Sustainability Fund, suggesting an underlying deficit of the same amount.

In January last year, the Care Quality Commission rated the trust as 'good' on use of resources, highlighting a low cost per weighted activity unit, good work on procurement and reducing agency staffing costs. (The 'good' rating came alongside an overall CQC rating of 'good', moving the trust from its previous status of 'requires improvement'.)

The use of resources report noted that the trust was delivering against its financial recovery plan. And Mr Orchard says not reporting a deficit is such a motivating state to be in – for the whole trust – that he is determined to continue making progress.

However, the Covid pandemic has completely changed the context for this financial improvement journey. 'This year has been a tale of two halves on the financial front,' he says. 'For the first six months, along with all providers, we were reimbursed for the full costs of what we needed to meet the pandemic. For the second half of the year we were operating within an envelope again.'

In conversation with: Devasuda Anblagan PhD

Devasuda Anblagan, Finance Manager for NHS England and NHS Improvement

Shortly after the UK's first COVID-19 lockdown began, Devasuda Anblagan started her first permanent finance role. Here, she shares her journey into public finance with **Anna Howard, CIPFA's Head of Qualifications & Membership.**

Devasuda began her career in the health sector as an MRI physicist. Arriving in the UK in 2005 on a scholarship from Malaysia and getting a First in Physics at the University of Nottingham, she was awarded a PhD, researching the MRI of foetal development in Nottingham before becoming a Research Fellow at the University of Edinburgh. She went on to complete the NHS Financial Management Training Scheme before becoming a CPFA in 2020.

Anna: I'm really interested in the work you were doing before you became a finance professional. When did you first become attracted to the public sector, and particularly public sector finance?

Devasuda: I've always been interested in how patients are served, and I'm passionate about improving the health and care they receive. My medical research background in academia was ultimately about contributing to patient health and wellbeing, and I knew that I wanted to contribute to public healthcare when I was doing my PhD.

But I began to feel frustrated by some of the funding models affecting research decision-making and long-term healthcare priorities – they seemed overly focused on fixing immediate, short-term problems. I started talking to colleagues and other people in the NHS about how this could be addressed, and one – an alumnus of the NHS Graduate Management Training Scheme – suggested I explore that route into NHS finance. For me, it was about finding another way to have an impact.

A: What do you enjoy about working for the NHS?

D: The NHS is very public-focused, and this completely aligns with my own values. The organisation I work in now creates an environment that enables innovation, encourages partnerships between people and organisations, understands the needs and demands of the population, as well as developing strategy planning aimed at improving people's quality of life. That was really key for me – improving the health and quality of life for the patients I serve, be it as a scientist, as an MRI physicist or through accounting.

A: What have been the highlights or biggest successes of your career to date?

D: I am very proud of my contribution towards improving the lives or the prospects of the babies who are born preterm, or babies who would have been going through pregnancy complications. Some of the research I did was around issues such as smoking, diabetes and substance abuse by mothers during their pregnancy, and how it might impact the baby's development. I published several journal papers over the 10 years of my academic career, but one highlight was publishing in Nature Scientific Reports.

In my finance career, the standout moment has definitely been working with NHS England and NHS Improvement on the COVID-19 response. Almost from the moment I joined, it was all about supporting the healthcare providers in the East of England – ensuring that the PPE was located and delivered to where it was needed the most in the first wave, and other important work to help tackle the crisis.

A: What do you think are the biggest challenges facing public finance professionals of the future?

D: There is too much focus on short-term goals and a failure to recognise that sometimes we need to choose or make short-term sacrifices to achieve greater benefit in the long term. That includes investing in research in certain areas, developing solutions and applying this to preventative interventions early on in life to avoid future, more costly treatments. Another challenge is encouraging people to join the profession – we need to do more around recruitment and training. And of course, we need to modernise and invest more into technology and innovation to get work done more effectively, efficiently and more sustainably in the long term.

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"Our recovery plans will be carefully balanced against the need for everyone to take time off and rest. Staff wellbeing is incredibly important to us"

This envelope included the continuing block contract income from the first six months, but stripped out the retrospective top-ups for unexpected Covid costs. And the trust's phase three plan also took into account the level of recovery that was expected at the time, although this did not account for such a high second wave of the virus. The result was a forecast £9m deficit, which needs to be seen in the context of its full-year financial improvement trajectory deficit target of £15m.

But the trust immediately set about trying to improve this position, recognising the importance of having a sustainable run rate for when the sector moves out of the current block contracting arrangements (which have subsequently been extended until the end of June).

'We immediately started to develop a recovery plan for getting back to break-even by the end of the year, so we could exit the year in good shape,' Mr Orchard says.

Additional costs

This was not a traditional cost improvement programme – clinical teams were rightly completely focused on meeting frontline demands – but it followed similar principles of weekly tracking across divisional run rates, non-recurrent opportunities and investments that had to be delayed because of the new surge.

Nearly £4m of the phase three forecast £9m deficit was the assumed cost of carrying forward holiday entitlement for staff, recognising that many staff have simply not felt able to take leave while the service has been under such pressure.

'By month 8 and reaffirmed in month 9, we had reduced our overall forecast deficit to £4.3m, which putting aside the annual leave issue, puts us really close to operational break-even,' says Mr Orchard.

The second surge has led to staff once again forgoing leave, and the cost of carrying forward this increased leave entitlement has been reassessed at £6.4m. In addition to this, the trust has allowed a further £1.5m to offer a wellbeing day to its staff – including staff at the trust's private finance initiative partner and its associated military hospital – as a reward next year.

However, taking into account commitments from the centre to cover providers' non-NHS income losses – a large part of which relates to private patient income and car parking – and, more recently, to cover an element of the annual leave costs, Mr Orchard remains focused on delivering break-even.

The underlying deficit will still be there when normal activity and funding rules return, but Mr Orchard believes the trust is in a good position to continue its improvement journey. After years of high spending on agency staff, this year the trust spent some five months without booking a single agency nurse shift – the result of a sustained international recruitment drive that meant the trust was actually over-established heading into the pandemic.

And a new two-year financial strategy aims to maximise resource, while eliminating waste. In the first year, the strategy will focus on optimising use of the workforce, eliminating waste and simplifying information and processes.

Mr Orchard's role as chief finance officer is supported by five teams covering financial services, estates, commercial services, procurement and charities. All have put in a significant shift over the last year. Procurement has been at the heart of keeping personal protective equipment flowing freely, while also ensuring equipment and supplies are in place to meet escalation capacity plans.

At times, the estates and facilities team has focused almost completely on site visitor and security controls, while at the same time ensuring vital utilities such as oxygen remain on stream.

Meanwhile, some finance staff have been formally redeployed or volunteered to support the front line – for example, helping with patient meal times or administering the vaccination hub.

But alongside these activities, the 60-strong finance team has also used the past year to review and redesign processes and reports. The trust will move to reporting the monthly finance position on the first working day of each month from April – following support from Leeds Teaching Hospitals NHS Trust – and it has eliminated business-critical supplier payment delays.

'This has been supported by cash advances this year, but we've also used the time to redesign all our processes so we are confident we can maintain and eliminate delays on any non-NHS invoices,' he says. New lead indicators have also been established to help teams more quickly understand their key metrics.

It is not a year anyone in the NHS will want repeated and significant challenges still lie ahead, both with continuing Covid-19 treatment and the further recovery of services. Mr Orchard says it has been undeniably exhausting and heart-breaking, given the toll the pandemic has taken on individuals and their families. 'But I've also loved being as close to the frontline as I'm ever going to be as an accountant and being part of the amazing response by the whole NHS.'

In conversation

A mini-series of podcasts, part of the *HFMAtalk* podcast launched in January 2020, aims to focus in on some of the key figures in healthcare finance. Hosted by former HFMA president and chief financial officer at Portsmouth Hospitals University NHS Trust Mark Orchard, *HFMAtalk in conversation with…* will feature current and former healthcare finance leaders, exploring their careers, motivations, experiences and lessons learnt. Keep your eyes on *HFMAtalk* podcasts for news about the first episode.

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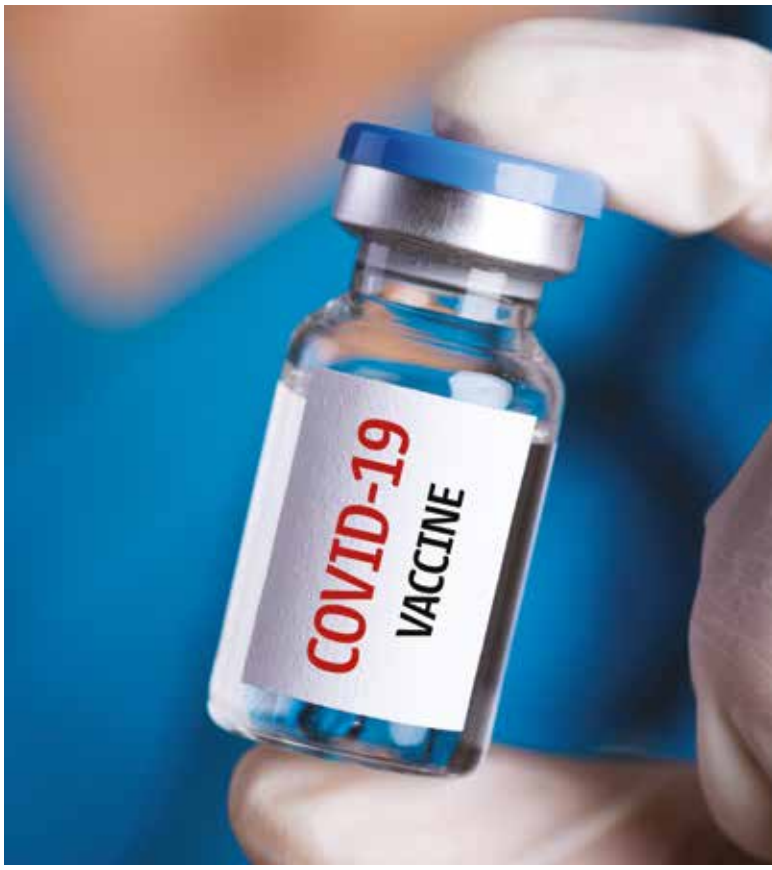

Across the country, finance professionals have been taking various roles in the UK's largest ever vaccination programme. Steve Brown talked to some of them

The NHS-led vaccination drive has been a major success to date, with local programmes started from scratch and centres staffed and opened within a matter of weeks.

This has involved significant partnership working between clinical teams, administrators and logistics, helping the programme to hit its initial targets and continue to push towards the ultimate goal of vaccinating the whole adult population. And you don't have to look far to find finance staff playing their own crucial part in the roll-out.

Sussex

Mike Jennings, chief financial officer for Sussex Community NHS Foundation Trust, is senior responsible officer (SRO) for the trust's vaccination centres and on the programme board for the whole of the Sussex vaccination programme.

These centres include a mass vaccination site in the Brighton Centre music venue, plus three further centres in Chichester, Crawley and Eastbourne. The venues operate in parallel with the GP-led vaccination programme, although in a couple of primary care network areas, the trust has partnered with GPs to help them deliver vaccinations to their local populations.

"We've effectively built a small trust using a mix of fixed-term contracts and bank arrangements"
Mike Jennings, Sussex Community NHS FT

'I got involved in early November and being SRO is a very operational role – like being a mini chief operating officer for the vaccination service.

But because it is so new, you're setting up a new service from scratch,' he says. 'It is not like taking on a service that already existed or even setting up a service for which a blueprint exists.'

This included creating standard operating procedures and recruiting all the staff. 'We were clear that we did not want to do this by depleting our core services, which were just starting to recover,' he says.

This has meant employing hundreds of new staff, supplemented by trust staff putting in extra bank shifts. However, there has been some secondment of back-office staff – providing, for example, digital support across the whole Sussex vaccination programme.

'We've onboarded more than 1,000 staff [third week of February], with more to go,' says Mr Jennings. 'So we've effectively built a small trust just to do vaccination using a mix of fixed-term contracts and bank arrangements.'

'Identifying sites and getting them up and running quickly was a key challenge – often having only a few weeks to kit them out, get the digital done, signing off everything you need for a building,' he says. 'But staff has been the big issue. Ensuring we have a fully staffed rota has been a challenge all the way through and is probably still our main issue.'

Being SRO is a very hands-on role with lots of problem-solving requiring immediate solutions – ensuring vaccines are moved around the system quickly, so that supplies are used within a given timescale or facilitating mutual aid between centres to keep rotas filled.

'As a finance director I've been involved in lots of things I wouldn't normally see – and that's been great,' says Mr Jennings. 'And there have been really tangible and immediate results, which as a CFO you don't always get. So although it has been tiring, there is a great sense of positivity and achievement that you take from it.'

He adds that he is grateful to his deputy, Ed Rothery, and his whole team, who have stepped up to enable him to take on the SRO responsibilities. The role is likely to continue until at least the autumn. However, although he says there is no such thing as business-as-usual for the vaccine programme, the executive team is talking about how it can mainstream the work.

'So while I'll still keep that SRO role, more of the responsibility I had during start-up will be shared more widely and that will become a smaller part of my day,' Mr Jennings says.

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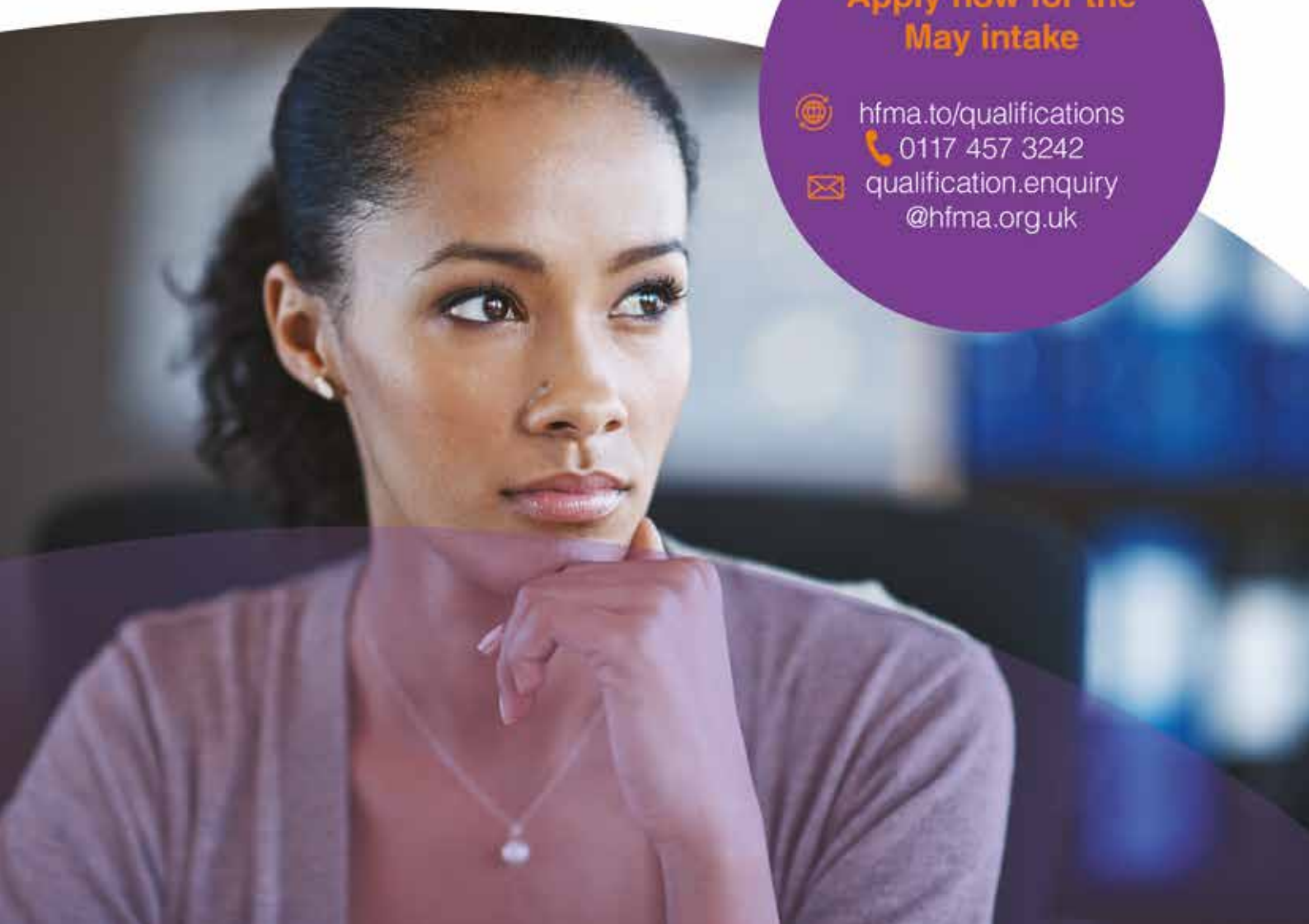

West Yorkshire

Further north, Alison Needham, head of finance at Greater Huddersfield and North Kirklees Clinical Commissioning Groups, has been at the heart of the area's vaccination programme.

Asked to nominate a member of her team in December to be the finance lead for the local roll-out of vaccines, she decided to take on the role herself, working alongside SRO Steve Brennan. With a slightly different structure to other areas, the programme has involved close work with primary care networks, the local GP federation, the Locala Community Interest Company that delivers community services and the local acute trust.

"As with the whole country, supply of vaccine has been sporadic at times, so you have to be ready to respond to that"
Alison Needham, Greater Huddersfield and North

To date, there have been two streams of work. There is the community programme, which started in December and now runs out of five local health centres and practices. And this was joined in February by a community vaccination site, running out of Huddersfield Town's football ground, the John Smith's Stadium.

'I've negotiated the lease for the stadium, sorted out all the cleaning and security and all the set-up costs – everything around setting up a new site with my colleague, Matt Whittaker,' says Ms Needham. 'I've done all the financial modelling, working with the project lead and the SRO, costing up staffing models and working with primary care on a day-to-day basis.

'Every day has been different,' she continues, adding that heavy snowfall has added an extra operational difficulty. 'And as with the whole country, supply of vaccine has been sporadic at times, so you have to be ready to respond to that. I've also had to sort lighting units for one of the sites, portable cabins and I've spent a lot of time most weekends looking for fridges [for vaccine storage].'

One memorable weekend found her chasing around Leeds trying to source an injectable training arm ahead of a visit to the vaccination centre by prime minister Boris Johnson.

While helping to set the programme up from scratch, Ms Needham has also taken shifts in the primary care operation and at the stadium. 'It was really rewarding,' she says. 'Some of the over-80-year-olds were so thankful to be getting the vaccine and some of them hadn't really seen anybody for a long time. And at the stadium, I spent six hours pushing wheelchairs in a half-mile round trip to bring people from the car park to the vaccination area – it certainly helped my daily steps total!'

As it started in February, the stadium centre had five vaccination lanes, but the plan is to ramp this up, enabling it eventually to deliver around 20,000 vaccinations per week.

Ms Needham says it is a team effort. While she is the finance lead on her patch, she works with finance colleagues in primary care, Locala, the GP federation and the local trust. 'It has just been a really joined up approach, with lots of unsung heroes behind the scenes,' she says.

With the programme set to continue possibly indefinitely, with talk of booster jabs in the autumn to combat new variants of the virus, it is not obvious how long the role will last. 'Once we get to an equilibrium – we know what we need to do, we know what the costs are and we know what the reporting structure is – my role will diminish,' she says. 'But I have to admit, it's been professionally really enjoyable.'

Phone lines

Working in a vaccination call centre gave Bill Bailey, finance manager at Sunderland Clinical Commissioning Group, a complete change of scenery from his day job. In the six weeks he worked in the CCG call centre – both taking calls and as part of the centre's management team – he says the work was intense and hugely rewarding.

Keen to get involved, he volunteered to be redeployed along with finance colleague Danial Connah, working six days a week. 'People were so grateful,' he says of his first experience on the phones. 'It was very rewarding, particularly the first few weeks.' He admits it was a shock to the system doing so much talking – and not about finance – and people's reaction to being offered a vaccine was overwhelming.

'Early on, we were talking to some of the most vulnerable people in the city – often in their 90s. I even spoke to someone over 100. Some people were in tears because they saw this as a way of getting back out of their houses and on with their lives.'

The job changed after a few weeks, when the phone number, which was only given out so that people could cancel appointments, started to be more widely known. All of a sudden, the call centre became a two-way operation and Mr Bailey then took on the job of fielding incoming calls.

This led to more challenging discussions if people felt they had missed out on initial vaccination invitations, and then when the government decided to postpone second doses.

"Some people were in tears because they saw this as a way of getting back out of their houses and on with their lives"
Bill Bailey, Sunderland CCG

Mr Bailey says the role was a huge contrast from his day job. 'During the day it was extremely tiring – you could sit down in the morning and not move from your desk until lunchtime. But it also gave you an opportunity to switch off more away from work. There were no half complete reports and no deadlines to worry about.'

The team turned in some heroic efforts. For example, the CCG received an additional supply of vaccine one Sunday – and given the time limit on using the Pfizer/BioNTech vaccine, it had to get enough people booked in over the following two days to make use of it. 'I had a team of 10 people and on this particular Sunday, from 9am to 5pm we booked 1,400 appointments.'

Mr Bailey has now stepped back from the call centre as year-end duties become more pressing and more appointments are being booked via apps.

He is pleased to have been involved and says he has also developed useful contacts and relationships across the system, while also gaining a healthy respect for people working in call centres.

He received thanks on a daily basis from people happy to be getting the vaccine. But Mr Bailey is also keen to thank his finance colleagues. 'I had a great experience, but it was only possible because of colleagues in the finance team picking up my slack.'

Humberside

Over towards the east coast, Tracy Mayes says that being asked to lead the Humber, Coast and Vale vaccination programme put her well outside her comfort zone. As deputy chief finance officer at East Riding of Yorkshire Clinical Commissioning Group, she held no fears about the finance and contracting side of the project. But operationalising the programme was a different scale of challenge.

'I've never been a programme director before and if the role had been advertised, I wouldn't have thought of applying,' she says. 'But my accountable officer asked me to get involved.'

With the local programme starting slightly later than other areas, getting things moving fast was imperative.

Ms Mayes says: 'Working with senior responsible officer Beverley Geary, we were tasked with starting the vaccination programme for the integrated care system from scratch,' she adds. It was initially envisaged as a three-day a week role alongside her normal finance role, but it quickly became obvious that it was a full-time job – and then some!

"Working with such a great team – even though it was all mostly virtual – was amazing"
Tracy Mayes (left), East Riding of Yorkshire CCG

Getting things moving involved setting up a programme office and appointing a management team, all seconded from NHS bodies across the patch, and designing the governance structure.

Eight workstreams were kicked off covering areas such as finance and contracting, workforce and estates.

In total, the programme team stretched to 10 people, expanding to 20 as single point of contact arrangements needed to be put in place 24/7 as the programme started running.

The programme soon made up for lost time, mobilising 34 primary care network sites, seven hospital hubs and two large scale vaccination sites, including the primary care-run site at Hull City football stadium.

The North East and Yorkshire region in general set the pace for the country in the vaccination programme and Humber Coast and Vale was a frontrunner in the region.

The region managed to vaccinate 70,000 people on a 'super Saturday' towards the end of January, and the Hull City stadium site on its own achieved 4,000 on another day. 'That is just a primary care practice that has done that, which is phenomenal,' says Ms Mayes.

Arguably the biggest challenge was being able to respond to guidance that could change multiple times in a single day and to be ready for anything. The team had set out expecting workforce to be the biggest risk. But it wasn't long before it became clear that vaccine supply was the real unknown – with the service needing to be able to stand teams up or down at short notice depending on deliveries.

However, Ms Mayes says that everyone they worked with was keen to help. 'You knocked on doors and you were immediately given "yes" as an answer,' she says, 'often before you had outlined the question.'

The biggest example of needing to stay nimble was when the team had just set up its system vaccination operation centre.

'Based on the information we'd been provided by our Ministry of Defence colleague, this was a physical centre,' she says. 'We'd sourced a location and we had the computers and the systems set up. We had a TV on the wall and all the maps we needed. We were ready to run that engine room and then the national specification came out and said that's exactly what you need, but you need to do it virtually.

'That was a real curve ball, we had to stand down the physical space and rapidly redesign for virtual delivery – going live within 48 hours.'

Ms Mayes recalls two particular highs she has taken from the programme. 'Working with such a great team – even though it was all mostly virtual – was amazing. The way we worked together was key to the success and the ability to mobilise,' she says.

But visiting one of the hospital hubs that they had helped to set up was a stand-out memory – seeing everything coming together. 'It was really overwhelming to see it set up and running and all those people getting their vaccinations.'

Ms Mayes returned to her finance role in February after four months in the programme director role. It has been a tiring experience, working every weekend, and she's glad to be back. But she is delighted to have played her part in the national vaccination programme and it has been a memorable and developmental experience.

Major challenges lie ahead for the national programme, especially as the country looks to start delivering second doses while continuing the roll-out of first doses, but confidence is high. Success to date has been based on multi-professional collaboration and finance professionals will continue to have a role.

For other examples of finance professionals 'doing their bit' to help the Covid-19 response, visit hfma.to/doingourbit. If you have experiences to share, contact steve.brown@hfma.org.uk

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Making it real

A new tool developed by Leeds Teaching Hospitals looks to take the theory of population health management and turn it into something that can be used practically by clinicians to target improvements in outcomes

Population health management – using data to guide the planning of care and support to achieve the maximum impact on the different groups of people that make up local populations – is a major buzz phrase at the moment. It featured heavily in the *NHS long-term plan* and local systems dutifully took up the challenge, putting it at the heart of refreshed strategic delivery plans.

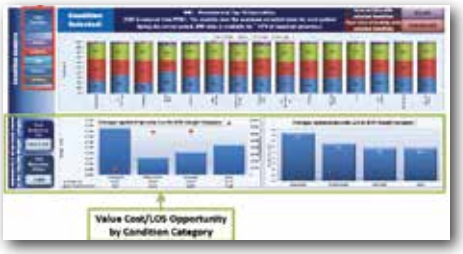
But while it is one thing to recognise the value of using data to help shape the right response to improve the health of different cohorts of patients and the population, putting it into practice is a difficult proposition. It requires the pulling together of multiple data sets and finding ways to share that data with the teams that can decipher what the data is saying and revise pathways accordingly.

A new tool developed by Leeds Teaching Hospitals NHS Trust may just provide a practical step forward and help clinical teams to start asking the right questions.

The trust's director of finance, Simon Worthington, says the idea is to look at cohorts of people who are or will become patients and look for ways to change outcomes proactively, taking account of all the wider determinants of health. 'This is not a new approach,' he says. 'But being able to do it practically has been really difficult.'

Finding a practical way to address this is important for Leeds, as a move to population health management is at the heart of the city's plan for improved health and wellbeing. A 'left shift' of resources upstream could mean that expanded hospital services are not necessary.

Developed by the costing team, the PLICS population health management analyser marries patient-level cost data with comorbidity and lifestyle information drawn from the trust's own patient data and from the Office for National Statistics.



The result is a tool that can be used by clinicians and others to explore the resources being consumed by different parts of the population.

It starts at a very high level showing the cost and population distribution across the city. Users can look at a high level across the whole city. For example, this reveals that, while each of the city's 33 wards has between 2.4% and 4.8% of the total population, resources spent on those communities range from 1% to 4.3% of overall costs. They can also analyse this by age, finding that while over-84-year-olds account for just 2% of the population, they consume nearly 6.8% of total resources.

Pulling in ONS data on the index of multiple deprivation (IMD) also highlights the disproportionate spend on people living in the most deprived parts of the city.

Users can then drill into the data, analysing the resources consumed at either ward or primary care network (PCN) level.

The analyser also highlights overarching figures on the public health context. For example, it can show levels of smoking or diabetes per 100,000 for each specific ward, putting this alongside other relevant information such as the outpatient did-not-attend rate for that ward and the associated households in that ward without a car.

Access to more data

However, this is only half the story. Arguably the real power of the tool comes from pulling in the trust's own data on lifestyle issues such as smoking status, body mass index (BMI), anaemia, diabetes and alcohol consumption.

This data is not currently available for all the trust's patients, but the costing team discovered it had access to far more data than it had initially realised (*see box, page 32*). It hopes that showing the value of having this data could lead to more comprehensive collection.

This separate analysis allows users to look at activity by specialty or geographic location through the lens of these different conditions and lifestyle issues. So, it will show you the split of activity in each specialty by BMI – healthy weight, obese, overweight or underweight.

It also shows the average inpatient costs for different specialties, such as cardiology or gastroenterology, and average length of stay by these different BMI categories.

An opportunity calculator will then show an indicative potential reduction in costs or length of stay that could be achieved if all patients moved to the 'healthy weight' category.

Vinod Bassi, assistant director of finance for business support and costing, says the tool doesn't answer the questions on how to improve health for different cohorts of patients. 'But it informs the questions that should be asked,' he says.

'By identifying the potential opportunities, you can start to ask how you might influence lifestyles. If you want to explore the impact that reducing smoking among gastroenterology patients could have, you can quickly see it.'

It is not about saving money – the cost data is just another patient-level dataset that contributes to the overall picture. But it can add to the case for making public health interventions to address lifestyle issues before patients come into hospital.

For example, anaemic patients tend to exhibit higher costs and longer lengths of stay. And it turns out that the trust will typically have the data on a patient's iron levels from blood tests, but previously has not made use of this information.

Iron deficiency can often be improved prior to a planned inpatient episode, but this requires changes to pathways.

Mr Bassi says that, although the tool is in its infancy, the response from clinicians has been positive. 'It is generating real enthusiasm and excitement,' he says.

One such clinician is Sophie Blow, an advanced clinical pharmacist at the trust with a focus on perioperative optimisation. She says that many of the things that could improve outcomes are related to comorbidities.

'But we struggle with knowing the numbers of patients we have with various conditions, where they come from and how to target them,' she says. '[We want to know if we] can do patient-centred care rather than just take a blanket approach.'

"This is not a new approach. But being able to do it practically has been really difficult"

Simon Worthington, Leeds Teaching Hospitals (pictured)

Being able to drill down into PCN level – the trust covers 19 PCNs – provides real insight. 'We have three PCNs that provide approximately 25% of our elective surgical patients and we can see that they account for among the largest numbers of smokers,' says Ms Blow.

The trust has access to a smoking cessation resource from Leeds City Council, although it is not currently used in a focused way.

"We struggle with knowing the numbers of patients, where they come from and how to target them. We want to know if we can do patient-centred care rather than just take a blanket approach"

Sophie Blow, Leeds Teaching Hospitals (pictured)

However, information provided by the analyser shows the potential benefits of targeting this resource at areas where it will have most impact.

Equally, it could be targeted at specific surgical interventions – there is a major link between urology and bowel cancer outcomes and smoking status, for example.

Ms Blow says changing smoking status, even a few weeks before an operation, can have a major impact on length of stay.

'It is different for different specialties, but most smokers will stay an extra day in hospital.' Reducing this is better for the patient and, in terms of freeing up capacity and reducing costs, it is a significant efficiency.

'It also gives the patient something they can do to support their surgical outcome and starts to build a partnership between the medical team and the patient,' she adds. '[The tool] has opened doors for us and given us opportunities that we just never had before.'

Added value

Martyn Robertson is an anaesthetics consultant with an interest in perioperative medicine at the trust. He agrees that the tool could become a really valuable resource, pulling reliable data sources together into a single place and making it analysable.

'It is really useful putting pound signs next to things,' he says, 'it gives you a potential. For example, if all the trust's cystectomy patients became ex-smokers from current smokers, how much would that save you from a surgical inpatient stay?'

Dr Robertson continues. 'And that is just the seven days in hospital.' If you add in the potential downstream benefits of making that earlier intervention, the patient and financial benefits really start to accrue.

Fellow consultant anaesthetist Alwyn Kotze agrees. '[When you look at it like this] the preoperative assessment, which we've always thought of as a way of preparing for surgery, becomes just another opportunity for

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Doctors of data

Vinod Bassi (pictured right), assistant director of finance at Leeds, says that costing practitioners have to be 'doctors of data' and make people aware of their data processing skills as well as their traditional finance competencies.

The trust's costing team includes a dedicated information manager who has passed on SQL programming skills to his colleagues. 'This has enabled us to access, extract and combine data in trust servers ourselves, rather than relying on the informatics department,' he says.

'Our philosophy is that we are privileged to have access to mountains of data that we use as part of our monthly patient-level cost production cycle. Using this to its fullest potential has meant that we have had to develop and evolve our analytical capability to convey what the information is saying to the people we are working with, so that they can drill into it and investigate the issues they are trying to examine.'

Awareness of the broader capabilities of the costing team have grown over the last couple of years, partly thanks to the team's Twitter account **@LTHTCostingTeam**.

The PHM tool grew primarily out of two initiatives. The team undertook some work to support a local anaemia collaborative. The collaborative wanted to improve the preoperative treatment of people with anaemia, which evidence showed would lead to lower length of stay and lower rates of blood transfusion. But it needed to be able to evidence the improvements that could be made to encourage roll-out among different surgical specialities.

Tom Mitchell (pictured left), cost accountant at the trust, said the challenge was linking to the right data. Coding for anaemia was poor, so a different source was needed. The costing team was used to matching blood tests to patients, to apportion costs. Now it realised it could also access the test results, providing a clear view of patients' anaemia status. And this enabled the trust to establish a baseline position against which improvements could be tracked.

On the back of this, other clinicians started approaching the team with requests for data to support their own improvement programmes. Another major step forward came with a project to explore the benefits of capturing more lifestyle information on the trust's electronic medical record PPM+. The team was given

access to some data from the Perioperative Quality Improvement Programme (PQIP) research database, which contained diabetes and smoking status, height and weight and anaemia results for a large sample of patients involved in research programmes.

It created a PQIP analyser and dashboard that linked all this lifestyle and condition data to costing data as a way of proving the concept. The commissioning clinician Martyn Robertson was thrilled, but things took off when trust finance director Simon Worthington saw the work. Recognising the potential to support the trust's population health ambitions, he asked the team to explore what data they could pull together using their own and available national data.

Mr Mitchell said that the real lightbulb moment came with the realisation that the trust had its own data on patients' lifestyle and conditions. 'There is so much in the back end, although sometimes we needed help from clinicians to find it,' he says. 'But once you've located it, if you have the SQL skills, the results can be revolutionary when you connect it back up to patient cost data.'

It is not comprehensive, but it is extensive enough to inform decisions. For example, the trust has smoking and height/weight data for around 45% of its patients. Alcohol consumption data is lower at 20% but anaemia is high at 79%. Patients' diabetes status is comprehensive because it is included in clinical diagnosis codes. And the trust feels that this position can be improved as more people understand the wider benefits of collecting the data.

improving long-term health,' he says.

While patient-level data has always allowed clinicians to drill into hospital data, the new tool 'allows us to look at the community impact', he adds.

Management and the board is also excited, seeing it as a practical way to further the trust's and wider system's population health management goals.

And with many of the actions to improve population health likely to involve system responses, clinical commissioning groups have also been briefed about the new analyser.

Rob Newton, the trust's associate director of policy and partnerships, says non-elective admissions are rising in most health systems, driven by comorbidities.

It is also well known that comorbidities are more prevalent in deprived areas. Typically, the inequality situation is expressed in terms of differences in years of life expectancy – often from a commissioner's perspective.

"We are privileged to have access to mountains of data that we use as part of our monthly patient-level cost production cycle"
Vinod Bassi, Leeds Teaching Hospitals

'The appeal of presenting information [in this way] is that we can see what inequality looks like from the trust perspective,' he says. 'If we go into our emergency department, we can use our own data to look at the direct impact of inequality. There is a real strength in being able to articulate this for us.'

Mr Worthington is convinced that the way the tool has been created, meeting specific requests from clinicians, will be key to its future success.

'As we move forward, this will be a really helpful tool and most of the work will be bottom up – that's the power of it,' he says.

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professional lives
Events, people and support for finance practitioners

Flexibilities roll over for accounts but further guidance expected

Technical

Usually at this time in the financial year, we have a fairly good idea of the new issues that have to be dealt with when preparing the annual report and accounts, *writes Debbie Paterson*. But, of course, this year is different.

Unlike 2019/20, it isn't a last-minute scramble for changes to the reporting requirements and we know most of the questions that need answering. It's just that we don't know all of the answers yet.

We do know that the flexibilities introduced in 2019/20 to make the preparation of the annual report and accounts less onerous are carried forward to 2020/21.

This means that the performance analysis and the quality accounts can be omitted from the annual report – quality reports are also omitted for good rather than as a temporary measure. Sickness absence data and staff turnover percentages can be replaced with a link to NHS Digital's website as long as the website includes that organisation's data.

The FAQs issued by the Department of Health and Social Care in relation to the *Group accounting manual* (GAM) in early January also provided the usual information about discount rates and the probability of non-recovery of injury cost recovery scheme income.

The *NHS foundation trust annual reporting manual* has now been published with very little change to last year, but it should be brought to the attention of the people that prepare the annual report.

The IFRS 16 leasing standard has been deferred again and will now be implemented from 1 April 2022. This means that it will be necessary to make the IAS 8 disclosures about accounting standards that have been issued, but are not yet effective.

This includes any 'known or reasonably estimable information relevant to assessing the possible impact that application of the new IFRS will have on the entity's financial statements in the period of initial application.'

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Although work on the application of IFRS 16 went on the backburner during 2020/21 as finance teams managed the impact of Covid-19, there was work undertaken in 2019/20 that should be used and updated to make this disclosure as full as possible.

NHS bodies should not forget that similar disclosures should also be made about IFRS 17 *Insurance contracts,* although the disclosure is likely to be that the standard has been published and will be adopted in 2023/24, but the impact has not yet been assessed.

NHS England and NHS Improvement have issued guidance on the accounting treatment of centrally procured equipment and consumables (personal protective equipment) as well as accounting for Nightingale facilities.

The centrally procured equipment and consumables will have to be reflected in the accounts of the NHS body that is using or has used them.

While the assets were bought centrally, they have been handed over to provider bodies that have taken control of them, and also get the economic benefits from using them, as they are used to provide healthcare services.

The arrangements look complicated and will need some administration but, basically, the Department will provide each NHS body with the information on the equipment and consumables they think they have provided to that body.

The NHS body will need to validate that information so that the final information can be provided in early April to allow NHS bodies to make the necessary accounting entries.

As the equipment and consumables are

continued overleaf

continued from previous page

provided free of charge, there will be equal and opposite entries, so the impact on the bottom line should be neutral.

Where the NHS body has not used the consumables at the year-end – the gain will be recognised in 2020/21 but the cost in 2021/22. The financial performance metrics used by NHS England and NHS Improvement will be adjusted to reflect this.

The accounting guidance for consumables is slightly different for those NHS bodies that do not usually recognise inventory in their accounts because it is immaterial. Again, the impact on the bottom line will be neutral.

Where NHS bodies do hold inventory, they need to consider how they will satisfy themselves of the accuracy of the year-end balances and whether that balance is likely to be material.

Where balances are material, auditors are required to attend stock counts – this resulted in qualifications of audit options in 2019/20 where stock counts were either not held or could not be attended due to the first lockdown.

If inventory is likely to be material, then NHS bodies should start to consider what arrangements they can put in place and how these might change nearer the year-end. It is also something that should be discussed with auditors.

Finally, for those bodies that are hosting a Nightingale facility, the guidance sets out the accounting arrangements and the disclosures that will be required.

NHS England and NHS Improvement are very clear that this guidance will be updated as decisions are made – particularly around holiday pay accruals and provisions for the Flowers case on overtime and holiday pay. Discussions with auditors are taking place around going concern and valuations.

While these issues are being considered and discussed nationally, this does not mean that no work should be done at an NHS body level. These are all issues that need to be considered locally and that bodies may want to discuss with their auditors.

There will also be another series of FAQs issued by the Department that is expected to include updates on the PDC dividend calculation, disclosure of off-payroll arrangements, disclosures around Nightingale facilities and accounting for centrally procured equipment and consumables.

Debbie Paterson is HFMA policy and technical manager

Technical review

An round-up of technical developments

Technical

The government has revoked a recently introduced rule that capped public sector exit payments at £95,000. NHS Employers said the decision was taken due to the unintended consequences the rule may have had on some employees. Redundancy payments will revert to the terms and conditions set out in the individual's employment contract or relevant scheme. **hfma.to/mar213**

NHS England and NHS Improvement are consulting on new rules for procuring NHS healthcare services. The proposed NHS provider selection regime would remove the procurement rules stemming from the *Health and Social Care Act 2012* and public contract regulations. Instead, organisations would use five criteria to identify the most suitable provider or run a competitive tender. The proposals allow for the continuation of existing arrangements, selecting the most suitable provider when a service is new or changed, and running competitive tenders. **hfma.to/mar214**

A new briefing from the HFMA examines current issues that mean NHS bodies are finding it difficult to appoint an external auditor. Informed by a survey of NHS finance directors, the briefing explores reducing interest in audit contracts among auditors, the increase in audit risks and concerns about auditor capacity. While fundamental change is required to the NHS external audit market, the briefing highlights actions that can be taken now by NHS bodies and the measures that will need to be nationally co-ordinated. **hfma.to/mar212**

New pay progression arrangements should not be delayed during the Covid pandemic, according to guidance issued by the NHS Staff Council Executive. From 1 April, there will be new pay progression arrangements for staff on Agenda for Change contracts. All pay bands will have one or two step points with specified minimum periods before progression can take place.The new guidance on pay progression covers the steps employers should take to prepare for the new arrangements and to account for the impact of Covid on an individual's progression. **hfma.to/mar215**

The quality of the activity data needed for costing is poor in key areas, according to a briefing from the HFMA Healthcare Costing for Value Institute and Grant Thornton. The briefing highlights areas where board members, system leaders and clinicians can support better data, such as ensuring information used for decision-making is subject to assurance and scrutiny. **hfma.to/mar216**

NHS England updated guidance at the end of January on how to account for the central pension contribution in 2020/21. Following a revaluation of the NHS pension scheme, the employer contribution increased by 6.3% to 20.68% from 1 April 2019. However, under transitional arrangements, the employer contribution was 14.38% in 2019/20, with NHS England and the Department of Health and Social Care contributing the remaining 6.3%. These arrangements remain in place for 2020/21, and the guidance sets out how the employer contribution will be accounted for in full by both commissioners and providers. **hfma.to/mar217**

The HFMA has published a briefing looking at the head of internal audit annual opinion. The opinion – a requirement of internal audit standards – is produced annually to support an organisation's annual governance statement. The briefing explains the requirements of the opinion and considers the key issues for 2020/21 opinions and in particular the impact of the Covid-19 pandemic and the NHS response to it. **hfma.to/mar218**

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Training

The past year has been a year like no other. NHS staff have faced unprecedented pressures arising from the Covid-19 pandemic – making major personal sacrifices and often working in difficult environments. And across the country, people have also had to come to terms with major changes in their home lives, *writes Steve Brown.*

The HFMA Academy wanted to understand how these dramatic changes had impacted on those studying for HFMA diplomas. So it asked a handful of learners about their personal experience of studying during the pandemic and in a lockdown.

Some 35 learners joined the programme during the year, joining others already on either the diploma or advanced diploma in healthcare business and finance.

Learners have had to negotiate increasing work pressures – long shifts, weekend working and fewer leave days in many cases. Some have been redeployed to support their organisations' response. Many in support functions have moved to home working. They've also seen home lives turned upside down as lockdowns have been imposed and they have taken on increased carer responsibilities or home-schooling duties.

For some, studying has had to be put to one side. For others, online delivery of HFMA diplomas has suited their new way of working. The flexibility of the programme and the fact that it was designed as an online course seem to have helped a number of people.

GP partner Michelle Brennan says the time commitment for studying was already significant, but it became particularly difficult during the pandemic. As well as general work pressures, she has recently taken a vaccination site lead role. Remote study is the only thing that would have worked alongside such commitments and she says that if she hadn't been granted an extension, she would have struggled to complete her assessment.

Similarly, Georgina Brixey-Worrall, a GP practice manager in Somerset, says that studying has often had to take a back seat to work demands. She is also involved with the local vaccine programme, which means weekend working, and says she is well behind on coursework and assignments.

But while there is no opportunity to take dedicated study time, she says the 'HFMA has been great at supporting me' and highlights the benefits of being able to log on 'when you have the time and energy'.

Others have found that studying can fit in well with working from home. There is less time lost in commuting, although workloads have increased across the board. Zoe Bladon, patient co-ordinator at The Royal Brompton and Harefield NHS Foundation Trust, has been working from home for the majority of the year and believes this has increased her capacity for online learning. However, she says: 'I have found sometimes my motivation levels can be quite low, as I am not changing environments as I would during a usual working day.'

A number of people pointed out that working from home meant that the vast majority of their time was now on screen.

'It is often difficult to find the motivation to study online having spent the whole day working online,' says Jonathan Gould, head of finance at Shropshire Community Health NHS Trust. However, he sees the ability to meet other learners online outside of work as a bonus.

Jayne Taylor, senior finance manager at Sheffield Clinical Commissioning Group, agrees it would be good to cut screen time – some form of text-to-speech software or facility would help she suggests. But again, she highlights the flexibility – being able to do a couple of hours early in the morning at a weekend or half an hour at lunchtime.

Ms Taylor is working more flexibly and the studying can adapt to accommodate this. And she adds that, with lockdown restrictions in place, there are at least no distractions from socialising.

'It has been a difficult year for learners on the programme,' says Academy head Emily Osgood (pictured). 'However, many have continued to meet the demands of study and have found some balance between work, home and learning commitments.

'A number of assessments achieved distinctions, which is very impressive given the challenges learners faced. We feel incredibly proud of them, but also of our talented tutoring team, who have continued to provide high level support throughout.'

One NHS Finance moves to next stage

Future focused finance

The One NHS Finance conversation relaunched on 1 February, when the finance community was asked to rejoin the discussion to help develop the key themes and outcomes that emerged from the first conversation that closed in 2020.

These key themes focused on developing our people, developing the finance community, and improving finance processes and systems.

Working with the Finance Leadership Council and Value Maker Network, Future-Focused Finance proposed new areas of delivery under these key themes.

Finance staff logged on to anonymously like, dislike and comment on the ways that they feel these areas of delivery could work.

In total, this final conversation, which closed on 21 February, received more than 15,200 contributions from over 2,000 finance staff. The contributions and data will be collated in a final report, which will include the updated vision for the NHS finance function, along with three proposed work programmes.

The work programmes will cover areas of delivery, including projects on: inclusion, diversity and equality; training and development; developing new ways of working through innovation; as well as looking at building stronger networks and creating a consistent offering for talent management across all band levels.

The One NHS Finance vision and strategy will be shared across the finance community, with delivery planned to start from September.

- **You can still access the conversations at www.onenhsfinance.org.uk**

Diary

All events continue to be delivered online

March

2 (H) Commissioning network: technical forum
3 (B) London: building high performance teams
4 (H) Audit conference
5 (W) An introduction to the NHS Business Services Authority
9 (W) Moving towards a value-based healthcare approach to contracts with industry
10 (B) Northern: premises law webinar
10 (H) Mental health conference
12 (W) Sustainability and reinvesting in the NHS: the case for exporting
17 (H) Chair, Non-executive director and Lay Member Network: chairs' conference
18 (B) Kent, Surrey and Sussex: building resilience and better life-work balance
19 (W) Year-end accounts issues 2020/21
26 (W) Managing employee engagement
26 (B) Northern: mini conference

April

1 (W) NHS Charities – year-end reporting issues
14 (I) Costing conference 2021

May

20 (H) NHS leadership and CEO network: forum

June

23-25 (N) HFMA summer conference

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

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

Branch contacts

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex elizabeth.taylor29@nhs.net
London leanne.lovelock@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern catherine.grant2@nhs.net
North West sara.braidwood@hfma.org.uk
Scotland fleur.sylvester@hfma.org.uk
South West leanne.lovelock@hfma.org.uk
South Central georgia.purnell@hfma.org.uk
Wales charlie.dolan@hfma.org.uk
West Midlands fleur.sylvester@hfma.org.uk
Yorkshire and Humber laura.hill36@nhs.net

Events in focus

Costing conference
14 April, online

The HFMA Healthcare Costing for Value Institute's annual costing conference provides the NHS with the latest developments and guidance in NHS costing, as well as increasing awareness of the collaborative approach needed to truly harness the power of data.

Chaired by Su Rollason (pictured), the chief finance officer at University Hospitals Coventry and Warwickshire NHS Trust, the day includes interactive workshops, case study examples and policy updates.

The event has been designed for both costing professionals and those not in a costing role but with an interest and role to play in the costing agenda. This is a must-attend conference for those needing support to improve costing at their organisation.

• **For further details, please visit** hfma.to/e52

HFMA summer conference
23 June-25 June 2021, online

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

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

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

The varied programme will ensure there will be something for everyone.

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

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

Looking ahead

Association view from Mark Knight, HFMA chief executive

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

My HFMA

Welcome to our first magazine of 2021. The team do a great job each week bringing you the very latest news and analysis via the *Healthcare Finance weekly* email, the website and the myHFMA app. But the quarterly print edition offers a longer read in a more traditional format.

As I said in a recent blog, the 2020 annual conference, held exclusively online, was a great success judging by the feedback. We recorded a 95% good or excellent rating – and the proportion of 'excellent' compared well with the face-to-face versions held in the past.

It was a long old two weeks, but many have said it was more democratic and accessible. More than 2,700 people logged in as opposed to the normal attendance of 600-700. I would like to thank all our staff and our wonderful chairs, Caroline Clarke, Owen Harkin, Suzanne Robinson, Mark Orchard and Sandra Easton.

And so, on to 2021! The government has set out its roadmap to remove all restrictions by June. But this pandemic has tricked us many times along this journey and we just don't know what the situation will be by December. However, with the marvellous NHS-driven vaccination programme going strong, we can have some confidence. And while there may still be some social distancing rules around, hopefully much of this year's annual conference will be able to go ahead in the normal way.

So, we are intending to run a week of conference from 6 to 10 December. The plan is for a hybrid event. Monday to Wednesday will involve online sessions, with the face-to-face event, in a newly refurbished London Hilton Metropole, getting under way on the Wednesday afternoon. These live sessions will be streamed out for delegates' colleagues watching back at the office. Please look out for how to take advantage of the early booker until 9 April.

A new initiative for us is a Membership Direct offering, where organisations pay for a block of individual memberships at a 15% discount. In return, organisations get a dedicated contact, who can co-ordinate membership centrally.

HFMA chief executive Mark Knight

SHUTTERSTOCK

At least 10 members have to enrol on the programme and employers can set up a system through their payroll to collect the fee. We expect several organisations to join this pilot and we are looking for more. For those that want it, it's a way of paying for the professional development benefits for staff as well as an option for groups of staff to receive a regular 15% off their personal membership subscription. For more information contact Danielle Lucas at danielle.lucas@hfma.org.uk.

On events, we continue with our usual programme, online of course – we are not planning to run anything face-to-face until at least September. Subject to the rules, and of course how members feel, we will then continue in a hybrid way and will be investing in some kit to help live stream many of our events.

Our policy team continues its excellent work and our presidential theme – *Taking pride in our future* – continues into a second year with a strong emphasis on digital and workforce.

One thing is certain: HFMA will continue to campaign for a funding settlement that will help the service build back, meeting the extra new needs it faces in the future. And for that we'll need all your help!

Member news

The HFMA **London Branch** held a number of lunch and learn sessions in December and January, including 'You and the new normal, virtual working with Microsoft', 'Negotiating and influencing' and 'ICS development' with Tim Jaggard, chief financial officer at University College London Hospitals NHS Foundation Trust (UCLH), and Rob Hurd, accountable officer at the Royal National Orthopaedic Hospital NHS Trust. Mr Jaggard will soon become acting chief executive at UCLH (see page 39).

A joint **South West** and **South Central** branches virtual student conference on 21 January gathered 130 delegates from across the region.

Katie Scott, a former graduate on the South West finance management training scheme, has won a global prize from ACCA for her studies. Ms Scott moved to London after completing the scheme and is now a management accountant at St George's University Hospitals NHS Foundation Trust.

The **HFMA annual general meeting** in December voted to revise its articles to allow Caroline Clarke's presidential term to be extended by a year. In addition:

- Owen Harkin and Lee Bond remain vice-presidents.
- Kim Li has become a trustee for her first three-year term.
- David Chandler and Maureen Edwards have been co-opted onto the board for their first three-year term.
- Elizabeth O'Mahony has been appointed trustee for her second three-year term.
- Carol Potter has resigned as a trustee.

National committee chairs were also appointed:

- Simon Crowther, Audit and Finance Committee
- Kevin Stringer, Governance and Audit Committee (third three-year term)
- Suzanne Tracey, Provider Faculty (third three-year term)
- Jane Cole, Commissioning Steering Group (first three-year term).

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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

Sue Hill (pictured) has been appointed substantive executive director of finance at Betsi Cadwaladr University Health Board. She has been in the post in an acting capacity since April 2019, when **Russell Favager** moved to Mid Cheshire Hospitals NHS Foundation Trust. Ms Hill joined the health board in January 2019 as finance director – operational finance. She has previously served as executive director of finance at Bridgewater Community Healthcare NHS Foundation Trust and deputy finance director at St Helens and Knowsley Teaching Hospitals NHS Trust.

Saba Sadiq (pictured) has joined The Princess Alexandra Hospital NHS Trust (PAHT) as its new finance director. She moves to the trust from East Sussex Healthcare NHS Trust, where she was deputy director of finance. She said: 'I am delighted to be joining PAHT at this exciting and challenging time. I am looking forward to working with colleagues and system partners to drive forward our ambitions.' PAHT chief executive Lance McCarthy added: 'I am pleased that Saba has joined us at PAHT. She comes with a strong history of improvement in the NHS and a broad experience of working in both acute and community settings and in partnership across health and social care systems.'

Claire Finn has been named as the new finance director of West Midlands Ambulance Service NHS Trust. She has moved from University Hospitals Birmingham NHS Foundation Trust, where she has been director of operational finance for the past year.

Arden and GEM Commissioning Support Unit has appointed **Mark Smith** (pictured) director of finance. He will be responsible for all areas of corporate finance, including maintaining strong financial controls, business planning, commercial strategy and partnership development. Mr Smith joins the CSU from Optum, where he was director of finance. This was preceded by four years at North Derbyshire Clinical Commissioning Group, where he served as acting chief officer and accountable officer. He succeeds the CSU's director of finance and deputy managing director, **Gill Scoular**, who is retiring after 40 years of service in the NHS.

Hounslow and Richmond Community Healthcare NHS Trust director of finance and corporate services **David Hawkins** has taken up the position of interim chief executive of the trust. An ACCA-qualified accountant, Mr Hawkins brings to the new role 18 years of experience across a range of NHS services, including providers, commissioners and community services.

The Royal Manchester Children's Hospital has appointed **Alice Forkgen** deputy director of finance on a year's secondment to cover maternity leave. She has moved from North West Boroughs Healthcare NHS Foundation Trust, where she is assistant director of contracting and transformation.

Preen to step down

Ros Preen (pictured) has decided to step down from her role as director of finance and strategy at Shropshire Community Health NHS Trust at the end of March.

Although not formally retiring, she has taken 'a positive personal decision' after working in the NHS for the past 33 years.

'I have some really positive things I want to focus on in the next six months or so, and I also want to take time to support my parents, who have always been there to support me when my kids were young.

'I know I will be looking for different things to do in due course, but right now I am just looking forward to taking each day as it comes.'

Her deputy, Sarah Lloyd, will become interim director of finance, while the trust is advertising for an interim director of strategy.

Ms Preen is a strong supporter of the HFMA. She has recently helped establish, and been chair of, the association's Healthcare in the Community Special Interest Group. She has also chaired the Mental Health Faculty, and is an honorary fellow and a former trustee of the association. She wishes to maintain those links with the NHS national finance network and continue to support the association.

'The HFMA has had a really important role to play in my career and, regardless of what I do next, I will want to stay connected with the association,' says Ms Preen. 'I can genuinely say the HFMA has been a very positive 31-year part of my 33-year career and it has been a very important part of my personal and professional development.'

Wes Baker is now director of strategic analytics, economics and population health management at Mersey Care NHS Foundation Trust. Mr Baker, who joined the health service as a biomedical scientist in 2003, and moved on to the NHS finance management graduate training scheme in 2008, is CIMA qualified. He has been with the Mersey trust since 2016, initially as head of financial integration and then strategic accountant (transformation and integration).

Tim Jaggard (pictured) is to take over as acting chief executive at University College London Hospitals NHS Foundation Trust from 1 April until late summer, when new chief executive **David Probert** takes up the post. Mr Jaggard is currently deputy chief executive and chief financial officer. Current chief executive **Marcel Levi** will be stepping down at the end of March. Mr Probert is currently chief executive of Moorfields Eye Hospital NHS Foundation Trust.

Paul Briddock at the 2014 HFMA annual conference
INSET: with colleagues at the HFMA 1994 Fincare campus

Obituary: Paul Briddock

The HFMA is mourning Paul Briddock, a former NHS finance director and significant contributor to the association, who died before Christmas.

Mr Briddock qualified with the Institute of Chartered Accountants in 1993, passing all professional body examinations at the first attempt, while working at Coopers & Lybrand. But he soon moved into the NHS, where he quickly built a strong reputation in NHS finance.

Initially, he joined the then Sheffield Children's NHS Trust as a financial accountant in 1994. He stayed with the trust for 10 years, rising through the ranks to deputy director of finance in 1997 and then director of finance in 1999. As finance director, his achievements included the delivery of annual surpluses, income growth, and leading a number of successful capital schemes.

Mr Briddock left Sheffield Children's in 2003 to take up the director of finance and contracting post at Chesterfield Royal Hospitals NHS Foundation Trust. There, he built on his reputation as a strong financial leader who developed good relationships with commissioners and oversaw a major capital investment programme to rebuild and refurbish the hospital estate.

After a spell as the trust's acting chief executive, he added deputy chief executive to his finance and contracting portfolio, leading the trust's transformation programme, with £6.5m of savings delivered in 2013/14. The programme also identified savings opportunities of between £35m and £59m over the following five years.

A stalwart of HFMA committees throughout his NHS career, Mr Briddock chaired the FT Technical Finance Group for six years, and led the association's Payment by Results Group.

In December 2013, he joined the HFMA as head of policy and technical, leading its policy, technical and research work, and acting as the association's spokesperson in the media and at conferences. He also helped develop and led the HFMA Healthcare Costing for Value Institute.

HFMA chief executive Mark Knight said it had been a privilege to have such an experienced finance director working as part of the HFMA staff. 'We had lots of great times working together. Paul fit really easily into the HFMA family,' he said. 'But I also remember him for his insightfulness and steady contribution to our executive team.'

After leaving the HFMA in 2017, Mr Briddock rejoined the NHS as director of finance for NHS England (North Midlands).

He was a devoted fan of Sheffield United FC and a keen cyclist. He combined the two in 2015 and 2016 in the Tour de Blades – long-distance charity rides where he represented the club, raising funds for Prostate Cancer UK.

Former colleagues remembered him warmly. Former HFMA chair Eric Morton appointed him finance director at Chesterfield. 'Paul was already a well-respected director of finance at a small specialist trust,' said Mr Morton.

'He grew into an accomplished director who gained the respect and affection of his colleagues at Chesterfield but also across the wider NHS. He was a reliable and perceptive finance director who had strong ethics and built up strong relationships within finance but also across all disciplines of staff.

'He had a keen sense of humour, which I assumed was a direct result of his dedicated following of Sheffield United. From his early days, he engaged widely in HFMA matters and became a strong advocate. He was a committed finance professional who leaves a strong legacy with those of us who were proud to have worked closely with him.'

Another former Chesterfield colleague, Ken Godber, said: 'Paul convinced me to put myself forward to chair the HFMA Charitable Funds Committee and it has been a very enjoyable and rewarding part of my career. Paul was a great boss, a great director of finance who continued to be a mentor to me, and a great friend.'

Keely Firth first met Mr Briddock in the mid-1990s, but their paths crossed again when she joined the HFMA FT Technical Finance Group and later when she became a trustee of the association. 'Paul was passionate about the NHS, very proud of his three girls and of course a loyal Sheffield United supporter,' she said.

Lee Bond worked with him for nearly 10 years in Sheffield, and they kept in touch as their careers progressed. 'He remained a close friend and a staunch supporter of all I have done in my career. He was 100% professional when it came to work and while I didn't always agree with how he did some things, I would never criticise why he did them. He was my teacher, my mentor, a good friend, and I will miss him dearly.'

Early booker discount available until 31 March 2021

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HFMA summer conference 2021

Reflect and reset

23 - 25 June 2021, online

#HFMAsummerconf

The HFMA summer conference 2021 will bring together providers, commissioners, mental health and community organisations as well as those working at a system level. The event will reflect on the impact of the Covid-19 pandemic, reset and look at the long-term implications for the whole system.

For more information and to book visit hfma.to/summer21 or contact Josie.Baskerville@hfma.org.uk

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