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Ending Change Paralysis in NHS Estates:

How to Forge Ahead in Uncertain Times

"Revolutionary treatments, technological developments, leadership structures, different funding... one certainty in the NHS is constant change. But there is a critical area that has proved notoriously slow to evolve: estates. Get it right and trusts, GPs and care homes can adapt to meet the needs of today's and tomorrow's patients and visitors. Fail to take action and hospitals and surgeries will not be fit-for-purpose, continuing to deteriorate and damaging patient services and user confidence."

- Sir Robert Naylor

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PRIME

News

Covid-19 could accelerate reform of payment system

By Steve Brown

Things have changed fast during the Covid-19 pandemic. The adoption of digital technologies to support virtual appointments is the obvious example (*see Diagnosis for the future, p18*). But the thinking around payment systems has also accelerated – with the end of episodic payment now likely to come far sooner than it might have done if the pandemic hadn't happened.

Over the summer, NHS England and NHS Improvement finally confirmed that the block contract arrangements put in place during Covid were being extended to cover August and September. A revised financial framework would then cover the remainder of the year.

There are two key differences in this revised framework. First is the removal of the retrospective top-up payments, which supplemented block payments to trusts in the first six months to cover providers' exceptional Covid-related costs. And the block payments will also be adjusted based on providers' performance against activity restart goals.

The tariff will feature in calculating the size of any adjustment – which will see providers lose 25% of the value of any shortfall in elective activity and receive 75% for overperformance (20% and 70% for outpatient attendances).

Beyond this year, the guidance is silent. However, there are increasing calls to rule out a return to simply paying for activity using national tariff rates. NHS England and NHS Improvement were already moving away from the old payment by results system, which is recognised as not supporting the move to system working and integrated care, before the country became consumed by the Covid crisis.

The switch to block contracts and the suspension of the contracting round has been welcomed by much of the finance community. It has encouraged collaboration and allowed people to focus on delivering outcomes.

Inevitably, some of this will be a response to the availability of funding – the government committed to finance not being an obstacle to the Covid response.

That largesse is clearly not sustainable and, even for the remainder of this year, budgets will again start to feel far more restricted. Even so, finance directors are keen that next year's payment system should build on the core elements of this year's temporary arrangements. The message appears to be: keep it simple and move forward not back.

So what might the service expect next year? The original plan for 2020/21 was to extend the use of blended payments to cover outpatients and (optionally) maternity services. In 2019/20, blended payment was set as the default mechanism for emergency care and adult mental health services, although it was not clear how much of the NHS had actually implemented these new approaches.

Chief executives told the NHS Confederation during the summer that there were concerns over a reversion to previous arrangements. Future funding mechanisms should encourage collaboration, not competition, they said. And a new system should incentivise population health rather than organisational health.

In June, the HFMA published *The future NHS financial regime in England*, in which it called for the introduction of aligned incentive contracts from April 2021. Under aligned incentive contracts, commissioners and providers agree objectives and a block value. They may also agree risk and gain share mechanisms to deal with changes in demand, activity or costs.

There are a number of such contracts already in place around the country – with slight variations in approach and different names – and NHS England and NHS Improvement are understood to see aligned incentive contracts as falling within a blended payments framework.

Under such an approach, the role for a tariff might reduce to informing the initial value of any block amount and supporting payments for activity that crosses system boundaries.

In line with the Confederation's call for payments to support population health, NHS England and NHS Improvement have said that they see blended payment as a stepping stone towards population-based funding.

But it is not clear what a population-based end goal might look like. In theory, it could involve capitated budgets set for systems to deliver all care for whole populations. Or it could cover sub-segments of populations.

Blended payments move towards this. With fixed payments based on realistic forecasts of activity using better cost data, this would be an improvement on block contracts based on historical spend, while avoiding the bureaucracy of detailed tariffs and in-year reconciliations.

Further downstream, there may be options to introduce more specific approaches for segments of the patient population – perhaps involving year-of-care or pathway-style payments.

The big change would be in setting overall objectives in terms of outcomes and allowing systems to pursue these in ways that make sense locally. However, it is a major leap from payment by results, which enabled the centre and ministers to drive specific responses by changing individual prices, adding in CQUIN quality incentives or introducing best practice tariffs.

NHS England and NHS Improvement are expected to engage with the service about payment system reform this autumn. Payment by results evolved over nearly two decades, but its demise could be much more rapid. There is agreement over direction of travel away from the tariff system. And with Covid-19 having made the break from activity-based payment, there is an opportunity to move rapidly to a new system.

Healthcare Finance

We've made some changes to *Healthcare Finance*. During the initial response to Covid-19, we started the weekly news bulletin *Healthcare Finance weekly*, delivered to members by email each Friday. The aim was to keep up with the fast-changing agenda during the outbreak, reporting events and providing comment, while also highlighting HFMA guidance and support and including the usual weekly news alerts.

This month, we've brought back the print version of *Healthcare Finance*. The magazine will now be published quarterly and will complement the continuing weekly online news.

It will provide more analysis and comment, while highlighting good practice and keeping you in touch with all the latest in professional development and who is moving where within the function.

HFMA survey highlights impact of Covid on year-end process

By Seamus Ward

Covid-19 has affected NHS frontline services and its support functions. For finance staff, the immediate impact was on the preparation of their annual accounts, with the countrywide lockdown announced just over a week before year-end. Professionally, it was a difficult time for staff, as outlined in a new HFMA survey.

The association surveys members about the year-end process annually, to inform its accounting and standards committee work programme, the pre-accounts planning conferences and to support national bodies' year-end reviews. This year the inevitable focus was on the effect of Covid on the accounts process.

"Organisations have struggled to appoint an auditor or have only had one firm bidding for the work"
Emma Knowles (pictured)

Overall, 86 responses were received from providers, commissioners and national bodies. Many said the pandemic had affected the preparation and audit of their annual report and accounts for 2019/20, though the impact was greater in some than in others.

Only half of respondents were able to work from home for the whole period of accounts preparation. Most were able to work at home for some of the time, though three said they had to go into work – one because they did not have the technical ability to work from home.

Some respondents told the HFMA that their employer had not put arrangements in place at the time the accounts were being produced in late March – which was later rectified – although only a small number said they felt unsafe when in the office.

Just over half of respondents said their accounts team was unaffected, but others reported they had fewer staff due to sickness, shielding or looking after children and not being able to work from home. A significant proportion of staff were deployed in other parts of the organisation.

At the beginning of the lockdown, implementation of IFRS16 was delayed by a year until 2021/22. The deadline for draft accounts was moved from 24 April to 27 April 2020, but providers could extend this to 11 May if they wished.

Although the IFRS16 deferral was widely welcomed, there was a mixed response to the deadline changes. More than a third (37%) said it was just the step needed. More than 40% said the extensions made little difference, and 21% said they were helpful but NHS England and NHS Improvement could have done more.

SHUTTERSTOCK

A number of finance staff felt the new deadlines put pressure on already hard-pushed accounts teams.

One respondent described the addition of three days for draft accounts as 'insulting', as two of those days fell at the weekend.

The April deferral had the knock-on effect of putting pressure on teams to close accounts as close as possible to the 27 April deadline.

As one respondent said: 'No-one wanted to be last and also audit needed to get going asap, so 11 May wasn't really a viable option. There was still a lot of pressure internally for an early completion date.'

While it was felt that audit went well, there were concerns about remote auditing – particularly with auditors unable to be present for stock takes – as well as the focus of auditors' work and access to senior auditors.

One respondent said the change in deadlines seemed to favour auditors, with the audited accounts deadline extended to 25 June. And an increase in the threshold for agreement of balances made little difference as auditors still asked for evidence of items below the threshold.

However, overall, 56% supported the increase in the threshold.

Finance teams said they have learnt to make better use of Microsoft Teams and to shift the year-end timetable to ensure information is provided earlier.

To overcome the difficulties around stock takes, some respondents suggested that in 2020/21 they would hold stock takes, with auditors present, in months 9 and 12, allowing the month 9 data to be used if auditors were not allowed on site on 31 March 2021.

Almost eight in 10 respondents supported making the move to electronic accounts submission permanent. Also, when appointing external auditors, accounts teams want auditors that can facilitate remote working.

The year-end survey comes amid wider concerns about the audit process and particularly about organisations' ability to appoint suitable auditors. Competition for audits has driven prices down, while the expectations on auditors have increased.

Some auditors suggest public sector contracts are no longer viable and there are some reports of trusts struggling to appoint.

HFMA director of policy and research Emma Knowles (pictured) said: 'We are aware that there are problems brewing in the NHS external audit market, in some cases resulting in fewer firms bidding for NHS audit work.

'Some organisations have struggled to appoint an auditor or have only had one firm bidding for the work. Worryingly, finance teams may be unaware of this until they are looking for a new auditor. Over the coming weeks, we will be looking into the factors behind the issue and asking members for their views.'

Providers insist trusts are restoring services to pre-Covid levels

By Seamus Ward

Patients must come forward when they need help as the NHS is rapidly restoring its services to pre-Covid levels, according to NHS Providers.

The member organisation said trusts were worried that the narrative about the NHS focusing only on Covid-19 had discouraged non-Covid patients. The NHS wound down some provision in its initial response and there have been subsequent concerns that cancer patients, for example, were not being referred to specialists or patients with heart attacks were not presenting at A&E.

However, NHS Providers insisted that, at the pandemic's peak, for every one Covid-19 patient in hospital, there were two non-Covid inpatients. Most mental health and ambulance, and many community services, continued to function at pre-Covid levels of activity or higher, it claimed.

NHS England and NHS Improvement are pushing for services to be restored. Guidance issued in July and August moved the service into the third phase of its response to Covid, incentivising a restoration of activity to near pre-Covid levels before winter.

In September, trusts should aim to deliver at least 80% of last year's overnight elective and

outpatient/day case procedures, rising to 90% in October. To support this, by October MRI and CT diagnostic capacity should increase to the same level as last year. And first outpatient attendances and follow-ups (face-to-face or virtually) should be at the same level as last year.

Performance figures for England showed the scale of the challenge. More than half the four million people on elective waiting lists have been waiting more than 18 weeks, the highest figure since records began in 2007.

However, NHS Providers also noted positive signs – there had been a 50% increase in the number of operations since June, while in July 25% more diagnostic tests were carried out than in June. Other figures, such as the number of cancer referrals, were also up.

NHS Providers said it was true that Covid constraints had reduced capacity by between 10% and 30% in some trusts.

But in a briefing, providers said trusts were demonstrating resilience and resourcefulness to recover service volumes.

Luton and Dunstable Hospital, for example, had created a new drive-through lung function testing system, while Epsom and St Helier University Hospitals NHS Trust had increased virtual outpatient appointments, expanded waiting rooms and used private sector units for elective care.

NHS Providers chief executive Chris Hopson (pictured) said: 'Chief executives tell us that they are recovering activity levels significantly faster than they were expecting to just two or three months ago.

'Trust leaders worry that the current unrelenting focus on what the NHS is unable to do, as opposed to how rapidly it is recovering services, is also discouraging patients from coming forward to seek help when they need it.

'The NHS is there for all patients, whatever their need.'

• *Diagnosis for the future, p18*

#DoingOurBit

During the pandemic, not only have finance staff been carrying out vital financial duties, but also helping out in other departments – from procurement, including personal protective equipment (PPE), to setting up a staff testing system. Some accountants have even worked in Covid wards, supporting their clinical colleagues wherever they can.

The efforts of finance staff have been catalogued in *Healthcare Finance weekly* and online at **hfma.to/doingourbit**. Some felt they could lend a hand as their finance work was curtailed following the introduction of the temporary finance regime, but many others have been helping out and completing their financial duties in their spare time.

Finance staff were able to use their skills to work laterally – interpreting large datasets, taking charge of daily sitreps, or managing PPE.

Alice Forkgen, assistant director of contracting and transformation at North West Boroughs Healthcare NHS Foundation Trust, used her audit experience to create a stock management system and ensure the trust had the PPE it needed, for example.

Northumbria Healthcare NHS Foundation Trust director of finance **Paul Dunn** and his team used contacts in local businesses to set up a factory to produce gowns.

Chesterfield Royal NHS Foundation Trust management accountant **Naomi Bennett** used her accountant organisational skills to set up transport for staff when local buses began running a Sunday service over seven days a week.

Others helped in PPE delivery. For example, **Ben Roberts**, assistant director of finance at Leeds Teaching Hospitals NHS Trust, was often seen delivering PPE to the wards from one of the trust's central stores or driving to a neighbouring trust to pick up supplies.

Darrell Tobin's expertise in big data helped him model the likely impact of Covid-19 on his trust – East Lancashire Hospitals NHS Trust. But some of his colleagues volunteered to support the front line. Senior finance officer **Abbie O'Malley** (pictured) has worked Saturdays in the trust's A&E department for the last eight years – alongside her full-time finance role. She responded to the department's call for help, working eight-hour shifts, six days a week. **Julie Walmsley**, divisional accountant for the trust's family care division, worked in an operational role in the obstetrics and gynaecology department.

News review

Seamus Ward assesses the past few months in healthcare finance

Covid-19 has prompted many people to seek out information on previously unfamiliar topics. Some developed an interest in the intricacies of epidemiology, oxygen saturation and the practice of proning. Others became regular visitors to the Office for National Statistics website – even becoming familiar with the name of their country's chief medical officer.

A lot has happened. The NHS wound down and is now ramping up 'normal' services. A new financial regime is in place. Practically all areas have been impacted. Auditors, for example, worried the pandemic would lead to fraud perpetrated against public bodies. The newly named Audit Wales (formerly the Wales Audit Office) said fraud against the public sector was a constant threat and the pandemic had 'generated an explosion in fraudulent activities'. The UK's first Covid-19 case was reported on 31 January and the first UK Covid fraud case recorded just nine days later, it added. However, the auditors heaped praise on NHS Wales, acknowledging it was leading the way among local public bodies.

Covid has thrown a spotlight onto social care – particularly how we look after our elderly and vulnerable in care homes – and to a lesser extent waiting times for hospital care. The many Covid victims dying in care homes prompted debates on funding and the future organisation of social care. The Health for Care Coalition, chaired by the NHS Confederation, told prime minister Boris Johnson a comprehensive and funded plan to support social care through the winter is needed or the NHS has no hope of clearing the backlog of routine operations. Patients would end up stranded in hospital without adequate provision in the community to care for them on discharge. The coalition urged the prime minister to honour his pledge to fix social care 'once and for all', and set out a reform timetable that met immediate needs and the need to put social care on a sustainable footing.

Health and care staffing has been one of the main themes running throughout the pandemic. The public showed their appreciation by clapping on Thursdays for all key workers, but, as some low-paid health and care staff pointed out, applause doesn't put food on the table. Workers on Agenda for Change have a pay agreement that lasts until next March, but in July doctors were told they would receive a 2.8% pay rise backdated to April this year. The Department of Health and Social Care said the uplift was in line with the *NHS long-term plan* funding settlement. It is worth up to £3,000 for consultants in basic pay. The Welsh and Scottish governments have also implemented the increase.

The level of future pay rises will depend on the outcome of the comprehensive spending review, due in the autumn. The government will have to balance many competing interests, including the economic impact of Covid and Brexit, the ongoing financial impact on health and care, and the needs of other spending departments, such as education. The review will set government department resource budgets for 2021/22 to 2023/24 and capital budgets for the years 2021/22 until 2024/25. It will also cover devolved administrations' block grants for the same period.

Building on the *Interim people plan* published last year, *We are the NHS: people plan 2020/21 – action for us all* considers the learning from the impact of the Covid pandemic and the consolidation of good practice. The lack of a finalised comprehensive spending review meant the NHS could not set out a

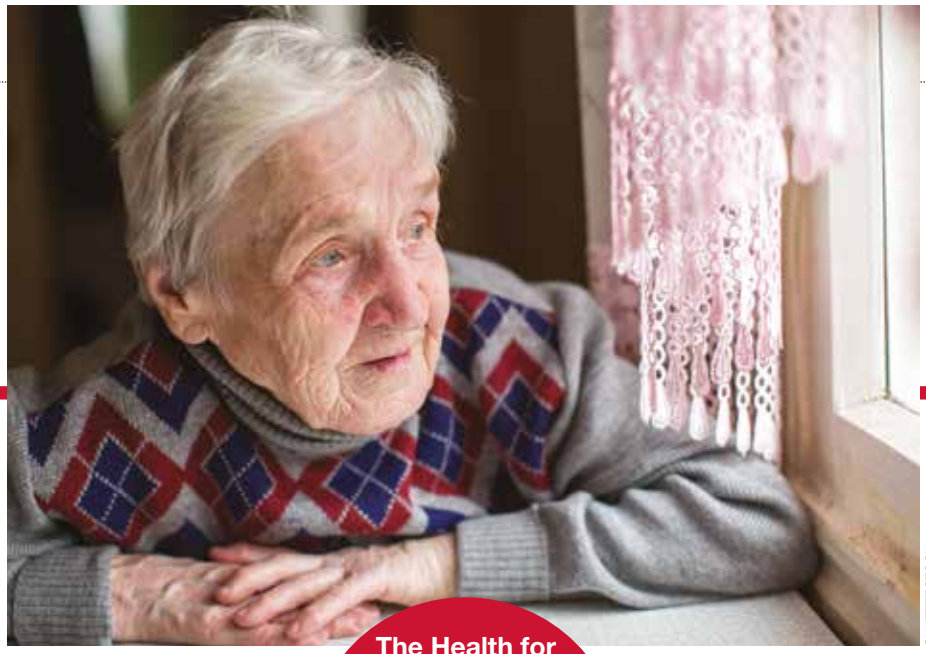
The month in quotes

'This year tens of thousands of healthcare workers have faced probably the most stressful period of their careers, with many putting their lives at risk and worse, but they're not being recognised for it.'
BMA council chair Chaand Nagpaul says pay awards for 2020/21 are not enough to thank doctors for their work during the Covid crisis and years of underpayment

'The pandemic has placed enormous pressure on colleagues. It has been encouraging to see remote mediations taking place so that cases can continue to be resolved without added stress to patients and those who care for them.'
NHS Resolution chief executive Helen Vernon sees the mediation process adapting under Covid-19

'Every person working in the NHS has contributed to an unprecedented national effort to beat back this virus and save lives. They have protected us and, in return, this government will do everything in its power to protect and support them.'
Health and social care secretary Matt Hancock backs the latest iteration of the *NHS people plan*

'This will mean the government is held to account by an evaluation process similar to that used across the NHS and social care system, which gives not just an absolute score but key pointers as to how to improve that score next time round.'
Commons Health and Social Care Committee chair Jeremy Hunt says its new rating system aims to focus minds on areas such as cancer



SHUTTERSTOCK

The Health for Care Coalition told Boris Johnson a comprehensive and funded plan to support social care through the winter is needed

five-year funding strategy, but the publication looks at areas such as staff wellbeing and physical safety and health. It also looks at the impact of technology adopted during the pandemic and governance processes, while promising flexible working and encouraging former staff to return.

Four Welsh NHS bodies failed to meet their financial duty to break even over three years, according to Audit Wales. NHS Wales' summarised accounts for 2019/20 said the four bodies had accumulated deficits of £354m over the past three years. Some progress had been made and the NHS Wales deficit had reduced from £96m in 2018/19 to £89m in 2019/20. The auditors said the financial statements were a true and fair reflection of the service's finances.

Meanwhile, the Welsh government has published a mid-point evaluation of its A Healthier Wales transformation fund, examining its influence on the adoption of new ways of working before the Covid-19 outbreak. Launched in 2018, the £100m fund covers all seven regional partnership boards, which can bid for funding for programmes that would align health and social care services, focus on primary and community-based care delivery and develop integrated prevention services. The report recommends closing projects that are not working and giving more time to projects to capture the necessary evidence of impact. Reporting requirements for different but similar funding streams should be harmonised, it adds.

The Covid pandemic shows the NHS needs a new financial strategy, with funding shifting to incentivising population health rather than organisational health, according to provider chief executives. They told the NHS Confederation it was unlikely the UK would emerge from the virus soon, so a new approach to finances was needed. A confederation report, *The NHS after Covid-19: the views of provider trust chief executives*, said national funding changes in response to the pandemic, such as the introduction of block contracts, were largely positive. But there was concern that the measures were short term and did not deal with the underlying financial challenges facing trusts. Chief executives welcomed the reduction in transactions following the introduction of block contracts, but feared the NHS would revert to previous arrangements.

The Commons Health and Social Care Committee is to trial Care Quality Commission-style ratings for ministers and national NHS bodies such as NHS England and NHS Improvement. Independent panels will look at four questions on progress with policy pledges – has the commitment been met or is it on track to be met; has it been effectively funded; did it achieve a positive impact for patients; and was the commitment appropriate? An initial pilot will examine progress against maternity targets.

The annual cost of harm from clinical activity under the clinical negligence scheme for trusts (CNST) fell from £8.8bn in 2018/19 to £8.3bn in 2019/20. In its annual report, NHS Resolution said provisions increased by £700m to £84.1bn. Maternity remained the highest value area for claims settlement, representing 50% of the total value of all clinical negligence claims received, 69% of the incurred cost of harm and 72% of the total CNST provision. The report includes the first year of the clinical negligence scheme for general practice, and describes the rapid launch of the clinical negligence scheme for coronavirus.

hfma

from the hfma

Despite the restrictions placed by Covid-19, the HFMA has continued to support and inform members in a number of different ways. The series of HFMAtalk podcasts, launched at the start of the year, was expanded and made more regular just after the lockdown was announced at the end of March. Sanjay Agrawal, HFMA trustee and consultant in respiratory medicine and intensive care at University Hospitals of Leicester NHS Trust, gave a clinical perspective of the impact of Covid in a series of podcasts. Others looked at different regions and countries of the UK, as well as sectors of the NHS.

HFMA president Caroline Clarke appeared on the podcasts and as a regular blogger. In the latter, she has covered a wide range of subjects, including the need to put an end to racism; the finance staff role in the pandemic response; and the importance of systems in bringing services back to pre-Covid levels.

King's College Hospital gastroenterology and general medical registrar Aamir Saifuddin gave a two-part account of the stresses at the front line and the lessons he has learnt, while NHS Nightingale Hospital London director of finance Rob Clarke took us inside the first NHS Covid field hospital.

Other blogs looked at the impact of Covid on charities and the ever-present need for a consistent supply of personal protective equipment (PPE). Bill Shields, former NHS finance director and now chief financial officer at Bermuda Hospitals Board, also had PPE on his mind in his lockdown diary, which reports his own experience of quarantine and self-isolation, as well as how the territory is responding to the pandemic.

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

Comment

September 2020

Back to school

Addressing public anxiety is part of the recovery challenge facing the NHS

I'm writing this at the start of September on the evening before my daughter goes back to school. She's not had quite the extended break that some kids have had (as keyworkers, we were lucky enough to send her to a small version of school during lockdown). But she's really looking forward to getting back to structure and seeing her friends.

HFMA president Caroline Clarke

Talking to other parents, many are still anxious about school restarting. We've seen this in the NHS too, with some patients not wanting to come into hospitals or GP surgeries. I've also watched the school take massive additional precautions, just as we've tried to in the hospitals and other care settings.

And I've realised that, no matter how great the precaution, it's going to take something else to allay anxieties. There's huge variation in public confidence and, as we go into winter, it's hard to know what else to do to shift things.

I do know that we will bust a gut to reduce waiting lists, that we will try to keep as many services open as possible in the event of a second Covid wave. And we will continue to learn lessons from the last six months so that we can make constant improvements.

But what else can we expect this term?

Apart from the obvious winter planning and ensuring that we are in the best possible position to face another Covid wave, there are a few more things on the agenda for the finance community.

- There's this autumn's

No drop in intensity

Finance staff have risen to the Covid challenge, but face a busy agenda

Healthcare Finance editor Steve Brown

It has been a half year like no other. Since the country first locked down as a result of the Covid-19 pandemic in March, NHS staff have performed heroics. And while the focus has understandably been on frontline clinicians, finance staff have played their part.

This has involved undertaking their normal activities in difficult circumstances. Accounts closure deadlines have been met despite finance teams moving rapidly to working from home. Finance staff have also managed the introduction of new financial flows and emergency governance arrangements, ensuring suppliers get paid promptly and getting new staff onto payrolls.

In some cases, they have swapped roles entirely to support their organisation's frontline response to Covid in other ways. We've tracked how finance professionals have 'done their bit' throughout the summer in a series of online reports (*see page 5 or go to* **hfma.to/doingourbit**). They've driven buses, sorted personal protective equipment, worked on wards, modelled the virus impact and supported the testing programme – to name just a few activities.

Participants at a roundtable (*Collective response, p26*) in September, organised by the HFMA and the Faculty of Medical Leadership and Management, explored clinical-financial engagement. It suggested that in some ways, despite many finance staff working from home, the finance function has become more visible during Covid.

If so, this visibility needs to be built on as the NHS looks to come back stronger.

Some new pathways are already in place, but continued transformation will need finance working closely alongside clinicians to understand the costs of new ways of working. It is only through collaboration that the service will identify opportunities for improvement. It will also allow it to move investment to prevention and different parts of the patient pathway to deliver better outcomes and value to the system overall.

There are significant challenges ahead. The impact of Covid-19 has created a huge backlog in elective activity and will almost certainly mean some patients will be presenting to the health service with diseases more developed than they might have been. And the Covid outbreak is not over yet – as the recent rises in infections have proved.

PRESIDENT'S PLAYLIST

MUSIC The artist that's united my household (adults Helen and Caroline, and Esmee, 10) is Lizzo. We've played her 2019 album *Cuz I love you* over and over again. I cannot wait for live music to start again.

BOOK I've just finished Reni Eddo-Lodge's *Why I'm no longer talking to white people about race* – a reminder about systemic inequality and white privilege. And I've started Eli Shafak's latest novel *10 minutes 38 seconds in this strange world* – a tale of non-traditional Turkish women and old-fashioned attitudes that still exist. Loving it already.

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

"I do know we will continue to learn lessons from the last six months so that we can make constant improvements"

comprehensive spending review, which should give the NHS a view on allocations for the next few years. There will be some big asks from the service around staffing and pay (the recently published *NHS people plan* is a bit silent on how we are going to pay for some of the commitments), capital to support infrastructure, and Covid recovery plans. And I hope it will be a chance to move from episodic funding to something more long term and stable.

- We have a massive number of people waiting a long time across the NHS and getting back to some kind of equilibrium will not be easy or quick. NHS England and NHS improvement have issued their 'phase 3 letter'. This is generating an industrial number of PowerPoint slides and templates and a lot of head scratching at system level about how we get the incentives right. Let's hope we can keep things simple. Don't over-complicate this year, and let's plan for a better future.
- The long awaited people plan, *We are the NHS: people plan 2020/21 – action for us all*, was quietly released in the summer. We should welcome the focus on staff wellbeing and inclusion. And as a profession we should be curious about the resource implications of some of the statements and should offer support and challenge.
- Local partnerships are solidifying all over the country and technology is emerging as a key enabler. I talked about this in my last blog *Going digital staying human* and I'd still encourage everyone to read the excellent report by Health Education England on what this will mean for the workforce of the future – **topol.hee.nhs.uk/the-topol-review/**.

For those of you who managed to have a break, I hope you've come back rested and ready for whatever the world throws at us. And if you haven't had a break, I hope you have one booked soon.

And I look forward to seeing lots of you virtually at the branch conferences.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

"The finance function's visibility needs to be built on as the NHS looks to come back stronger"

Aside from this twin challenge of addressing the backlog while maintaining Covid capacity, finance professionals need to ensure their voice is heard as the service implements new payment systems (*see page 3*). There is growing support to use the opportunity afforded by Covid – and the break from activity-based contracts – to accelerate the move to something that supports system working and the delivery of integrated care. New governance and approval mechanisms – building on the trimmed down processes hastily put together to support fast decision-making under Covid while still providing assurance and control – will also need finance professionals' input.

And behind this agenda, the function faces other pressures that will shape its future – as set out in last year's report from Future-Focused Finance (FFF), the HFMA and PwC, *Designing our future*. First, there will be a move to system working, whether that involves increased partnership working or some form of structural change. There are opportunities to make greater use of technology such as cloud computing, artificial intelligence and robotic process automation and to reduce time spent on data gathering to make more time for data analysis.

The latest finance staff census (*Finance in profile, p10*) arguably shows a baseline against which future changes across the function may be measured.

Finance staff numbers have remained broadly unchanged over recent censuses. The massive agenda facing finance might suggest that this general trend will continue. However, beneath this headline measure, the focus of the function and how it goes about its business may change more radically.

Finance in profile

The HFMA's biennial finance staff census gives a detailed picture of the function, with staff split by organisation, age, pay band and qualifications. Steve Brown sets out the vital statistics

Finance staff numbers working in provider and commissioner organisations have remained relatively stable over the last 10 years despite structural reorganisations. The function is highly qualified, experienced and motivated. However, there remain issues with the most senior levels of finance teams not reflecting the make-up of the function as a whole, both in terms of gender and ethnicity.

These are the high-level messages in the latest finance staff census and staff attitudes survey looking at the NHS finance function in 2019. The census – a collaboration between the HFMA, the Skills Development Network and Future-Focused Finance – is conducted every two years and provides a detailed breakdown of the NHS finance function, looking at where people work regionally and by organisation type, qualification levels and the profile of finance teams in age, gender and ethnicity.

The HFMA staff attitudes survey complements this headcount analysis by adding in the views of a sample of the finance community.

In total, the 2019 census recorded 16,788 finance staff across 507 organisations, including non-core bodies such as NHS Property Services and central and regional teams from NHS England and NHS Improvement. This represented a headline increase of 345, or 2%, since 2017 (see chart, facing page), though this includes a rise of 374 staff in non-core bodies, the numbers of which differ from census to census.

Focusing just on the 226 provider bodies and 206 commissioning bodies (including clinical commissioning groups, commissioning support units (CSUs) and specialised commissioning teams), there were 15,035 staff in place at the end of June 2019. This represents a reduction of 716 staff in providers and commissioners since the census was first conducted in its current detailed format (broken down by Agenda for Change pay bandings) in 2009.

Some of the differences are down to the different treatment of specialised commissioning finance teams in different years. However, there was a significant drop in numbers in the 2013 census, reflecting the abolition of primary care trusts and strategic health authorities and the increased use of shared services, particularly by new CCGs.

But in the last three censuses, overall finance and commissioner finance staff numbers have remained broadly unchanged, around 15,000, despite there being 25 fewer organisations in 2019 compared with 2015.

Provider numbers

Looking at the 15,690 core NHS finance staff – those working in providers, commissioners, NHS England and NHS Improvement – four-fifths (12,545) work in provider bodies, with more than three-quarters of these (9,769) working for acute trusts. Mental health trusts account for a further 17% of provider finance staff, with community (400) and ambulance trust (287) making up the balance.

On average, an acute trust employs 66 finance staff compared with 40 for a mental health trust, 29 for ambulance and 25 in a community trust. These averages are distorted by the size of the organisations, with finance team size typically increasing with turnover. More than 100 of the 146 acute trusts have turnover of £300m or more. But just 14 of the 51 mental health trusts, and no community trusts, have turnover this size.

Taking into account turnover, average finance team sizes are more similar. For example, for a trust with a turnover of between £200m and £300m, the average finance team size is 46 (acute), 38 (mental health) and 38 (community). Use of shared services or outsourcing – or the provision of services to other NHS bodies – will also have an impact on finance team size. Four-fifths of all providers outsource one or more financial services. The most frequently outsourced service is internal audit (74%), but this is closely followed by payroll (62%) and accounts payable/receivable(48%/47%).

In the case of accounts payable and receivable, this reflects an increase since 2017, and there has also been a six percentage point increase in the number of providers outsourcing all of these functions.

Commissioning

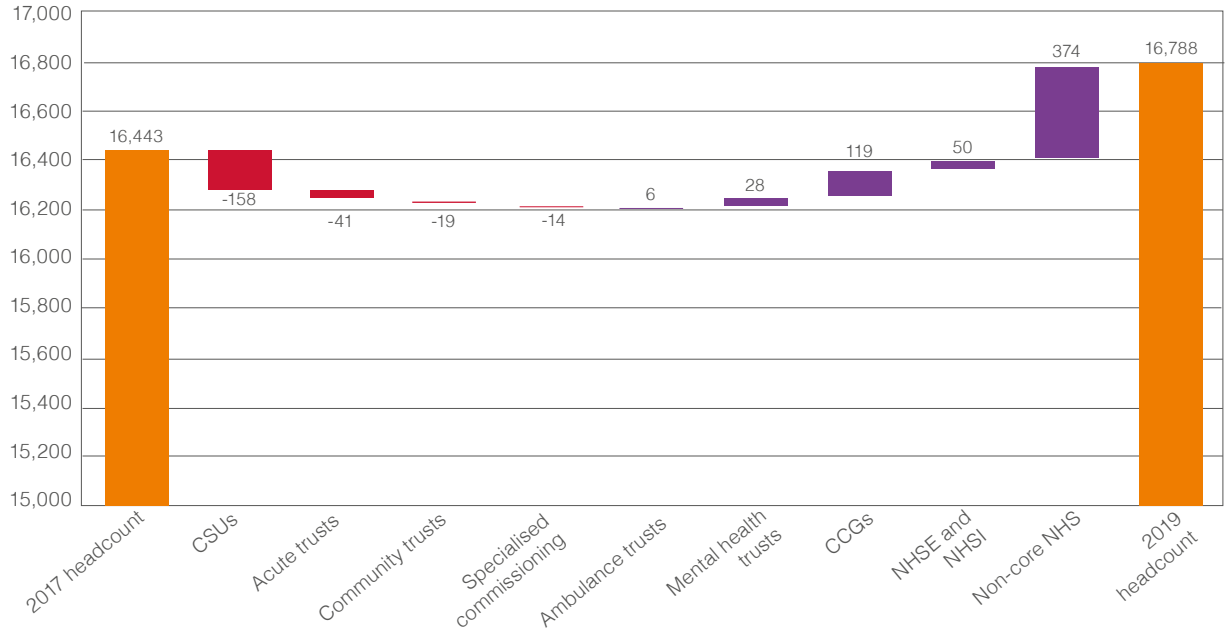
Of the 2,490 staff working in commissioning, four fifths (2,050) work in CCGs with the remainder split between CSUs (402) and specialised commissioning (38). The average size of a CCG finance team is 11. This is a small increase in the average of nine in 2017, reflecting both a reduction in the number of CCGs (down 16 to 191) and a small increase in CCG staff overall (up 119).

The average size of a finance team varies depending on location – from seven in London to 20 in the South West. Looking at the numbers of staff in post per £bn of allocation, the average number of staff ranges from 17 in London to 40 in the North West.

Several CCGs were sharing chief finance officers (CFOs) and finance teams and many submitted a combined census return. This joint working was in some cases a precursor to mergers that have taken place since the census was completed.

The NHS as a whole faces significant staff shortages and the census suggests the finance function has its own challenges in this area, with a 7% vacancy rate, considering staff in terms of whole-time equivalents.

Change in finance staff numbers between 2017 and 2019



The census continues to show that the finance function is highly qualified and relatively senior. More than 40% of the function is band 7 or higher (including finance directors and senior managers not on Agenda for Change rates). London has the highest proportion of senior staff with 54% band 7 or higher. It also has the lowest level of staff in bands 1-4, possibly reflecting higher levels of shared service usage for transactional processing.

The majority of finance staff also have, or are studying for, some kind of finance qualification. Nearly one in three is qualified with the CCAB or equivalent body, while a further 12% are studying for this level of accountancy qualification. Some 12% are qualified or studying for AAT. Just over 40% of the function has no finance qualification.

For the first time this year, the census has also collected information about the age spread of the finance function. It shows that 57% of staff are aged between 35 and 54, with fewer than 20% 55 or older. Just 15% (745) finance managers in band 8a or higher are aged over 55. Looking specifically at finance directors, 23% are aged 55 or older and one in five is 44 or younger.

There may be a good age balance at director level, but the function still has work to do in having women properly represented at the most senior levels. Women make up 62% of the NHS finance workforce, but the position is exactly reversed for band 8d and above. And just 29% (132) of finance directors are women.

While this represents a step forward since 2009, when there were only 75 female finance directors, representing 21% of all directors, the improvement is more marginal compared with 2017. The 2019 numbers represent an increase of five director positions filled by women and just a one percentage point improvement.

Two-thirds of all women in NHS finance are at band 6 or below (45%

SHUTTERSTOCK

Career focus

Stability is arguably the defining characteristic of NHS finance careers. Most staff taking part in the HFMA staff attitudes survey have been in their current position for more than two years and many with the same organisation for more than a decade.

More than 600 finance staff responded to the fourth biennial survey – which was conducted last year before the Covid pandemic – almost all of them holding CCAB or equivalent qualifications. Just over 60% said they had been in their current role for more than two years and 27% with the same organisation for at least 10 years; 34% had spent their entire career in the NHS.

More than two-thirds think NHS finance offers sufficient career development opportunities. But some identified limited scope for progress in their organisation and few opportunities for secondments.

Finance staff feel positive about their roles, scoring an average of 6.9 out of 10 for job satisfaction – reversing a downward trend from previous surveys. In general, job satisfaction rises with age. Although 69% would like to spend the rest of their career in the NHS, only 52% expect to do so.

In terms of working hours, 70% of staff work in excess of their contracted hours at least once a week and one in five say they always work in excess of contracted hours. Close to two-thirds of respondents think NHS finance is more stressful now than in previous years.

Views on how finance is valued have changed little from previous surveys. The vast majority (88%) think their finance team adds value to the organisation – although better communication with non-finance staff and improved financial literacy of non-finance staff would increase that value.

Almost half feel valued by their board, but more than a third do not feel valued by the government and health department. However, people felt drawn to the NHS because it fits with their public sector values.

Looking to the future, 40% of the sample thought the finance function needed to be bigger to meet demands placed on it. However, 45% thought it would be smaller by 2022/23.

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NEP Shared System Group is the largest not for profit Consortium in the English NHS. For over 18 years, NEP, hosted by Northumbria Healthcare NHS Foundation Trust, has been providing leading edge procurement and finance solutions utilising the latest technologies to support the NHS. Ahead of the curve, NEP have during the past 24 months, implemented a 'true cloud' Software as a Service (SaaS) solution utilising Oracle Cloud ERP.

Using this technology has taken the NHS to a new level, in terms of enabling new features and enhancements on a quarterly basis with the assurance of being supported by Oracle technology. Working collaboratively with our partners has enabled us to offer the best solution to support the National Agenda and specifically to support the digitalisation of the NHS.

One key example is where we have worked concurrently with our Partner Pagero, as our PEPPOL access point for NEP, engaging and driving more Suppliers to trade with the NHS. Working with Pagero and engaging with our Consortium with the full support of our NEP Organisations, we have successfully adopted over 450 suppliers who are already trading via PEPPOL with NEP Organisations. Operationally, this means that purchase orders are transmitted electronically across the PEPPOL network and supplier invoices transmitted back in the same way. This removes all of the manual intervention and processing element, providing a seamless transmission saving considerable resource and cost in the purchase to pay process of the system. What is really exciting is that NEP has taken this a step further in developing a process enabling the same methodology for invoices between NHS organisations. Although in its infancy, the pilot has gone extremely well and we envisage this will be a real game changer in not only how we interact with trade suppliers, but also in the removal of manual process between NHS bodies.

NEP offer technologies that give our clients the ability to formulate and promote best practice and provide opportunities to our members that normally wouldn't be available for years under an 'on premise' stand alone solution. The distinct benefit and where NEP Cloud has come into its own, has been the ability for all our members to work remotely from home during the COVID-19 pandemic. The flexibility the NEP Cloud solution offers has undoubtedly helped support our organisations through a very difficult period, without interruption to service. This includes maintaining the full P2P flow within the NHS ensuring critical delivery of essential supplies to hospitals and from a financial perspective all month end, year end and audit deadlines being met in all cases by NEP Consortium Organisations.

NEP strides towards ensuring best value, best technology and best service for the NHS and its true essence is achieving this via collaboration. NEP works diligently to deliver the best solutions and services for the NHS.

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of men). The change in balance between women and men as you move up the pay bands can be seen clearly in the chart below.

The census also highlights a continuing imbalance in the ethnicity of NHS finance staff, which increases with pay grade. Organisations chose not to disclose ethnicity for 6% of finance staff in total and 4% of directors – a smaller number than in 2017 – and the census reports the proportions of different ethnic groups as a proportion of all those for which information was provided.

Some 75% of NHS finance staff were white British (78% in 2017) – though this increases to 92% at director level. London has a different ethnic make-up, with just 36% of finance staff being white British. However, some 74% of finance directors in the capital are still white British. London organisations chose not to disclose the ethnicity for a higher percentage of all finance staff (10%) and directors (5%).

Figures published this year suggest that 20% of all staff working for NHS trusts and CCGs in England in 2019 were from a black and minority ethnic background. This compares with 22% of NHS finance staff at CCGs and 23% at provider trusts who are not from a white British background. Some 23% of women in NHS finance as a whole are of an ethnicity other than white British. The equivalent number for men is 29%. At more senior levels – band 8d and above – these proportions drop to 16% and 15%.

HFMA director of policy and research Emma Knowles says the census is an important way of tracking the finance function over time. 'This was the original aim when we launched the census a decade ago – to see how the function changed in numbers and make-up as structures and the requirements placed upon it altered.

'On the face of it, numbers have stayed relatively stable, apart from a reduction reported in the 2013 census largely related to commissioning changes. This reflects the important role undertaken by finance staff at all levels – it is an essential function playing a crucial part in the delivery of high-quality, sustainable services as well as supporting accountability arrangements. But there have been changes within the function.

'For example, it is generally more qualified and more senior now than it was in 2009 – 43% of finance staff are now qualified with or studying for a CCAB qualification or equivalent. This rebalancing towards more senior staff reflects moves away from transactional processing – including the greater use of shared services in some cases – and towards more value-adding roles such as business partnering.'

Monitoring and remodelling

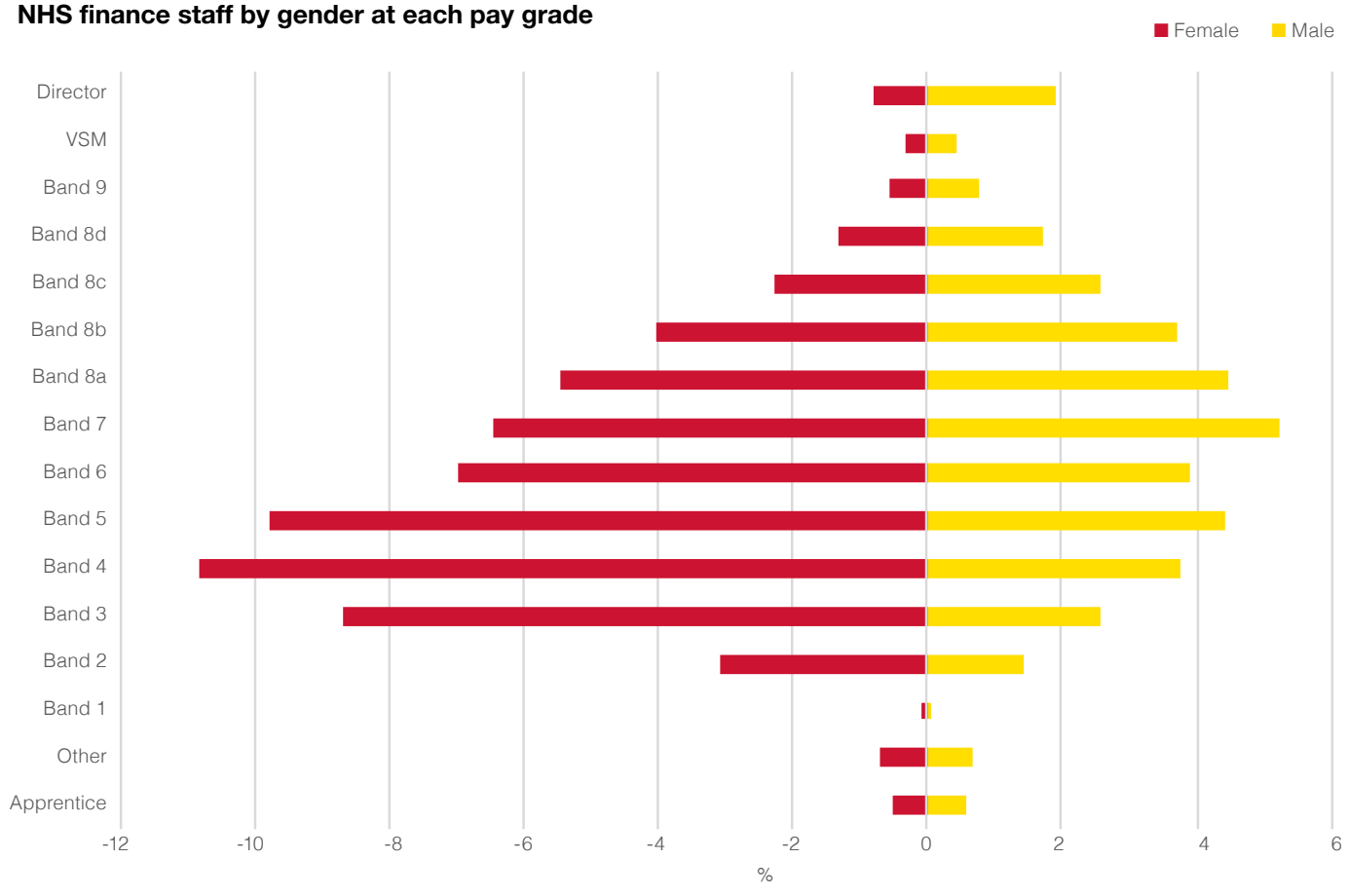
Ms Knowles believes that this monitoring of the function will continue to be important as the finance function looks to remodel itself to support greater system working and take advantage of technology developments.

The association published *NHS finance: designing our future* last December, in collaboration with Future-Focused Finance and PwC, to start a discussion about how the function needs to adapt, and the census will provide a mechanism for monitoring the impact of any changes.

However, Ms Knowles acknowledges that the census also highlights where NHS finance needs to do better. 'The NHS finance function continues to have a diversity problem in higher paid roles when looking at gender and ethnicity,' she says. 'The finance function and the NHS is poorer for not reflecting the communities it serves.'

The function has started to address the diversity issue – with work being led by Future-Focused Finance – the census is a reminder that there is still a long way to go.

NHS finance staff by gender at each pay grade



no ordinary accountant

To mark his retirement next month, past HFMA chair Paul Cummings talks to Seamus Ward about his career and why he believes accountants should spend more time on the front line

Asked what he would do differently if given the chance to change any part of his 30-plus years in the health service, Paul Cummings thinks a moment, then says: 'I'd try to listen more and speak less. I'd try to spend more time at the coal face – because we can be all about balancing the books and not much about the quality of care.'

That doesn't sound like a typical accountant's answer. He replies by telling a story about being asked by JK Rowling's charity, Lumos, to talk to ministers and officials in Bulgaria about resettling children with learning disabilities from long-term institutions. 'I was introduced by the head of Lumos as the first accountant they'd met who talks like a social worker – that's the best compliment I've ever had.'

Taking up this theme, Mr Cummings says social care must receive as much attention as acute services. 'It's about getting the balance between what happens in hospital and what happens outside. You can make a difference in how you fund Early Years and change children's lives and make a bigger difference in the long run.

He speaks with compassion and sincerity, talking warmly of the people he has met, from porters and security guards to consultants and ground-breaking medical researchers.

Having trained at Northern Ireland Electricity (NIE), he admits to 'falling into' working for the Health and Personal Social Services – Northern Ireland has an integrated system. But his rise was rapid, and he got his first director of finance job at Belfast's Mater Hospital, aged 27. 'The Mater was the most rewarding job in my career,' he says. 'It was an organisation that was small enough to spend a day in theatres, or with the physiotherapists or to work with the nurses for the day. You get to understand the business at that level.'

Now director of finance at Northern Ireland's commissioner, the Health and Social Care Board, he holds firm to the importance of getting to know the business. 'When I was working at a trust, trainee accountants would spend their first two weeks as porters, on the night shift or in A&E.

'I learnt that at NIE – for the first year they didn't let you near finance, you worked in a showroom, a power station or with the overhead linesmen. So, when you went into finance, you knew who to ring if there was a problem. It gives you credibility.

'But it must be a two-way street – sometimes the doctor needs to be in charge of the finance; in patient-level costing, maybe a clinician needs to be the lead, not the finance team.

'I say all the time to staff: the more you get out, the more you are able to do your job. Listen to patients and carers.'

The Mater's location, close to Republican and Loyalist communities in the city, meant it often cared for the casualties of the Troubles. Mr Cummings recalls a bomber, the injured and relatives being treated on the same ward; paramilitaries stationed in corridors guarding their organisation's members; and a hospital security guard being shot. And the violence meant not knowing if the route to work or home would be disrupted.

> **"I've gone from being the most junior accountant to director of finance for the whole of Northern Ireland"**
> **Paul Cummings**

Even so, he adds: 'It was tremendously rewarding. The team in hospital faced adversity and was united, regardless of background, and saved many, many lives. For such a small hospital, it did some ground-breaking work and when I go back there, people still know me even though I haven't worked there in 20 years.'

In 2003, he was the first person from outside the English NHS to become HFMA chair, and he feels this was a turning point in his career.

'In Northern Ireland, we think we are in some way inferior to the rest of the UK, but when I took up the post as chair I realised the work we were doing was just as good. They had as much to learn from us as we had from them.

'This is something I think the HFMA doesn't do enough of. We need to make sure the whole of the UK and beyond learn from each other.'

Learning from others

The US/UK exchange was a way for him to continue learning from other health systems. But, as well as being good for professional development, it produced enduring links. Indeed, involvement in the HFMA has given him lifelong friends. 'For me, people are the most important thing. It's why I was able to send a team to see how Wales was dealing with patient-level costing despite Covid.'

Mr Cummings led the profession in talks about the Agenda for Change pay structure – a pivotal moment for NHS finance staff across the UK. 'It was about where we sat in relation to other professions. There was a real

Clockwise from above: Paul Cummings with Chris Calkin at the 2017 HFMA conference; on stage at the end of his year as chair; at Northern Ireland's Health and Social Care Board; on the cover of Healthcare Finance in 2002; and at conference 2003

danger we were going to be downgraded as a profession. But the work we did showed the worth of the profession and, after that, we were not seen as a support service but a vital equal around the top table.'

There were concerns that new starters in some lower paid grades – payroll, for example – could see their salaries reduced by up to 30%. Mr Cummings successfully argued for changes in job profiles to protect salaries.

Coming to the English health system as an outsider worked in his favour, he believes – he was able to say things others could not. Without the intervention, newly qualified NHS accountants would have started on Band 6 – negotiations led to them being set at Band 7.

Success in the negotiations gave the association a new confidence, he adds. 'I think the HFMA was just getting up and running after it split from CIPFA. It was finding its feet and realising that it could promote itself and provide tremendous value to its members and the whole health service.'

Back in Northern Ireland, a secondment to the Northern Trust had a profound effect. 'I was brought in not because of the money but because of patient care concerns. There were challenges around A&E and the clinical governance of staff. A review uncovered 21 historic serious adverse incidents, where the trust fell far short in its care to individuals, resulting in significant harm or death. There was a culture that needed to be acknowledged and changed. It took courage not to ignore that but it was the right thing to do.'

In the headlines

Local and national media picked up the story. 'Appearing in front of the media to apologise on behalf of the trust was difficult, but meeting families to apologise for the death of their loved ones were the most difficult days of my career. We let them down and nothing I could say would change that.'

Asked whether he has enjoyed his career, Mr Cummings states: 'Absolutely. I didn't choose a career in the health service, but I wouldn't have stayed if I didn't enjoy it. I am in favour of using your accountancy skills to influence policy and strategic decisions. In the health service, your ability to influence people can't be underestimated. As a director of finance, don't think you do not make a difference. I have letters from clinicians stating how many people are alive now because I got them the funding.'

He leaves the service predicting tough times ahead, particularly around workforce, as he feels too few people are joining the caring professions. He would like to see the politics taken out of health, and longer-term planning for financial and strategic decisions.

Retirement will mean a break from work, but at 57 he's not about to spend his time playing golf – which he took up two years ago – though he is hoping to work on his 20 handicap. 'I want to do something where I feel I can make a difference,' he says.

Making a difference is what this accountant who talks like a social worker has long done.

A career in finance

Paul Cummings trained as an accountant with Northern Ireland Electricity (NIE) before joining the Eastern Health and Social Services Board in 1987.

'I fell into it,' he says. 'NIE had a European grant to train three accountants every year, but when I qualified, they didn't have a job for me as an accountant. I was supernumerary, but I didn't want to sit around waiting.'

A job came up in the local NHS. 'I was lucky enough to get it, but it means I started in the same building I'm finishing up in – I've gone from being the most junior accountant to director of finance for the whole of Northern Ireland.'

Things have changed a lot since he joined the service. He remembers with a chuckle his first day, when staff broke for morning tea, served in china cups, with the director of finance. 'Computers were just starting to be used in offices and the finance director said: "Get this man a computer. In fact, get him two".

'So, I was given one of the first 286s, which nobody knew what to do with, and [spreadsheet program] Lotus 1-2-3, which I had to go on a course to learn how to use.'

Mr Cummings has held a number of finance director posts in Northern Ireland, the first at the Mater Hospital in Belfast. 'I've just had my 30th set of accounts signed off – all of them unqualified, which is not bad.'

Establishing a blueprint for a sustainable NHS

How NHS investments in technology are reaping greener rewards

Across the world, businesses and organisations have been forced to adapt in response to the coronavirus pandemic adopting digital processes to mitigate the disruption caused.

This has resulted in businesses having to accelerate their digital transformation journey - but whilst the NHS has worked to mitigate the impact of coronavirus and focussed on treating the health of the nation, its investment in technology has enabled it to adapt in terms of efficiency and accessibility, whilst also placing sustainability at the forefront of its outcomes by putting sustainable processes in place.

Looking towards the future, the NHS has recognised that climate change also poses a major threat to our health as well as to our planet, which in turn has direct and immediate consequences for patients, the public and the health service itself.

In January 2020, NHS Chief Sir Simon Stevens announced the launch of the 'For a Greener NHS' programme, which aims to mobilise the 1.3 million staff across the NHS to take action. The main goal of this programme is to build on the excellent work already being done by NHS Trusts throughout the UK and encourage the sharing of ideas to help reduce the impact on public health, save money and eventually go 'net carbon zero'.

This programme is certainly one of a kind, positioning the NHS as a leader in sustainability as the only major health system in the world to tackle climate change from all angles. However, to succeed requires support and participation from the NHS staff, along with suppliers and partners of the NHS to establish a standardised baseline for sustainable practice.

Technology plays a key role in supporting the move towards more sustainable practices and is included as a main pillar in the NHS's long term plan - which sets out a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS.

This outlines a commitment to improve the use of technology to make 30+ million outpatient appointments redundant, sparing patients thousands of unnecessary trips to and from hospital, whilst reducing the use of resources through digitisation of processes such as document management.

As part of the NHS's long term sustainability plan, there is also an emphasis on reducing waste with a focus on the materials used, minimising waste where possible. Investment in technology is of course a key component of reducing waste, with many NHS Trusts looking to move to a paper-lite office environment, which leverages technology to move from paper intensive processes to more efficient and streamlined digital processes.

The HFMA Environmental Sustainability Special Interest Group has been working diligently to ensure NHS Trusts are recognised for implementing good practice in embedding environmental and social sustainability.

They ensure these processes and the wide range of benefits offered are highlighted across the NHS to progress the groups move towards financial and sustainable success. This includes operating within safe financial and environmental limits, to developing robust, resilient and future proof models of prevention and care.

Lexmark's work with Aintree University Hospital (AUH), now part of Liverpool University Hospitals NHS Foundation Trust (LUHFT), was recognised at the "NHS in the North Excellence in Supply Awards", as an example of how working with a committed

sustainable supplier, can have a major impact – not only on the efficiency savings throughout the trust but ultimately on the environment.

The five-year smart Managed Print Services agreement has seen Lexmark consolidate Aintree University Hospital's print devices by over 70%, improved information security and further aims to reduce its paper usage by 30%+, providing a platform on which to drive continuous improvement and control.

Aintree University Hospital has also implemented the Lexmark Cartridge Collection Programme (LCCP), part of Lexmark's zero-landfill policy. The programme ensures materials extracted during the reclamation process, including plastics, various metals and toner, are reused in packaging and parts to further protect our natural resources.

As a result, Aintree University Hospital alone recycled 659 units equivalent to 828 kg of materials recovered, equal to 2,889 kg of CO2 savings or 1,225 litres of petrol use avoided.

Like LUHFT, Liverpool Women's NHS Foundation Trust (LWH) also needed to respond to the 'For a Greener NHS' a programme create to drive digital processes and reduce waste paper in the office. As few hospitals can make the jump from paper-based processes to fully digital in one step, LWH turned to Lexmark to review its existing printer fleet, and recommend and then implement a solution to support the journey towards 'paperless'. LWH chose Lexmark to consolidate its unmanageable, costly printer infrastructure to reduce costs, eliminate waste and support a drive towards digital working practices.

Since implementation, Lexmark MPS has consolidated LWH's devices by over 30%, with a 70% reduction in spend and a 20% reduction in page volumes on a year on year basis. Following on from these promising results, LWH plans to now use this project as a platform to adopt further "paper-lite" initiatives through a modular approach.

The success of Lexmark's integration with LWH and its shared desire with the team at the Trust to proactively action the 'For a Greener NHS' programme is an achievement the Liverpool Women's digital transformation team are keen on sharing. LWH are looking to collaborate with NHS Trusts who would like to leverage their experience of effectively managing output as part of a broader digital strategy, to share their experiences among NHS Trusts and suppliers alike.

Everyone who works in healthcare, or works in partnership with healthcare organisations and services has a responsibility to take action on the health emergency posed by climate change. Through sharing best practices and proactively driving towards more efficient, sustainable processes we can all play a part in improving patient care and reducing the impact on the environment on delivering such care.

Sylvie Thomas
Head of EMEA Sustainability Policies & CSR, Lexmark

Lexmark

"Our successful implementation with Lexmark is a prime example of how the NHS can work with sustainable suppliers to create examples that can be shared with other NHS Trusts to move the service towards an efficient and greener future. The tangible benefits of the project are testimony to the work the NHS has done in establishing a sustainable blueprint across the service from NHS staff, to suppliers and partners of the service."

Raquel Quinteiro-Silva
Sustainability and Energy Manager
Liverpool University Hospitals NHS Foundation Trust

"At LUHFT, we are dedicated to ensuring our investment in technology supports our future growth alongside our commitment to the environment. Our work with Lexmark reflects this ethos, delivering a tangible return on investment that furthers our digital transformation journey in an ethical and sustainable manner."

Ian Jones
Deputy Chief Finance Officer /
Director of Finance (Operations)
Liverpool University Hospitals NHS Foundation Trust

"For the success of the NHS' long term plan, it's imperative that sustainability is high on the priority list for finance and procurement teams when selecting suppliers. Not only has our work with Lexmark reduced our print spend by 70%, it has also enabled us to create a sustainable foundation from which we can continue to build on."

Matt Connor
CIO
Liverpool Women's NHS Foundation Trust

diagnosis for the future

Covid-19 has prompted the faster acceleration of technology than planned by the NHS. But where has the tech been useful and what role will it play in the recovery of patient services? Seamus Ward reports

Businesses often marvel at how slowly the NHS changes, tied, they say, to a plethora of business plans, seemingly endless committees and a bureaucratic approval process. Though the perception may have some truth to it – and there are often good reasons for NHS caution – during the Covid-19 pandemic the service has perhaps shed some of its reputation for glacial pace of change.

By necessity, changes have been made quickly. Hospitals have sprung up in a matter of weeks. Beds have been freed up and new testing systems created from scratch – though these measures have attracted criticism for their impact on patients and efficacy.

But one of the biggest changes visible to patients is the adoption of new ways of working, often driven by the speedy adoption of technology the NHS has been planning to use for years.

England's health and social care secretary Matt Hancock and NHS England chief executive Simon Stevens have spoken warmly about the new ways of working, with Sir Simon insisting the health service must retain positive changes, such as new technologies around patient care, to support recovery of services.

The NHS has been promising to adopt technology that makes patient access easier and improve clinicians' productivity for years. The *NHS long-term plan* – published in 2019 – commits to the wider use of technology and digitally enabled care, to reduce hospital visits and enable earlier discharge, for example.

The operational planning guidance for the current financial year – superseded by Covid – says many face-to-face outpatient appointments could be carried out using technology or are not needed at all. Tangible progress was expected during 2020/21, setting the NHS a goal of avoiding a third of face-to-face outpatient appointments by 2023/24.

Covid-19 has accelerated adoption of alternatives to face-to-face outpatient appointments and few would argue that tangible progress has not been made. The NHS England and NHS Improvement June board meeting heard that 'substantial and accelerated progress' has been made in redesigning outpatient care, in particular by using video and telephone consultations. More than 80% of trusts now have access to video consultation facilities, with more than 250,000 video consultations delivered across services in the year to date. This level of coverage already exceeds the goal the national bodies had set for this year and they expected further progress.

Board papers conclude that 46% of services were delivered virtually in March (post-lockdown) and April 2020, compared with just 6% in February and March (pre-lockdown). In primary care, most consultations were delivered via video/phone at the height of lockdown.

Many trusts use the Attend Anywhere web platform for video calls – NHS England and NHS Improvement have bought licences for all trusts until the end of the financial year. The national bodies offered providers training and up to £20,000 per provider to purchase equipment, though the latter is available regardless of the video consultation platform chosen by trusts. Video consultations would be reimbursed at the same level as face-to-face activity under old tariff rules. Attend Anywhere has also been used across Scotland, branded as NHS Near Me, since 2016.

Nuffield Trust researcher Rachel Hutchings says the pandemic has led to an acceleration of many ambitions for the NHS, particularly surrounding digital technology. 'This is in areas such as online triage and remote consultations in primary and secondary care,' she says.

The centre has also shown flexibility, as well as providing practical steps to support providers.

Challenges have included concerns about data privacy and the difficulties inherent in bringing together different and complex systems. 'You have to get the infrastructure right, ensuring people have the right equipment and access to the internet,' says Ms Hutchings.

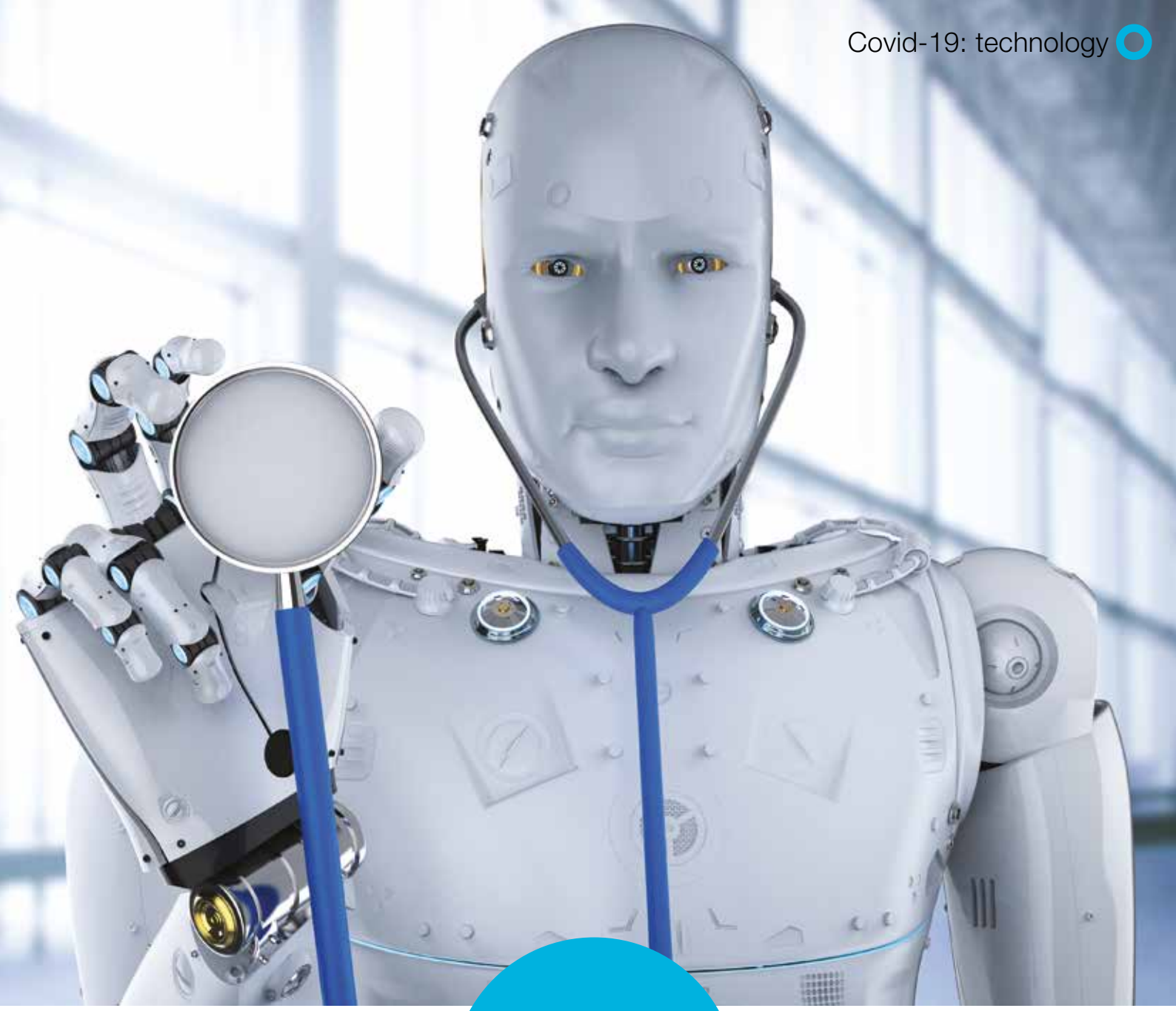
Training and investment

The equipment will often involve capital spending, but there will also be revenue consequences. 'Digital technology is not something you have as a one-off cost; it requires ongoing investment. You have got to keep on top of it.'

Clinicians must also be trained so they feel comfortable using it. The Nuffield Trust identified this in a 2019 report, says Ms Hutchings. 'We said there is always going to be an underlying issue that technology spending isn't a one-off, it's also about the whole package around it, whether that be improving the technology or making sure there is investment in training and supporting staff.'

While coronavirus prompted trusts to seek alternatives to face-to-face meetings and appointments, the NHS phase 3 Covid response plan has provided further incentives. In the short term at least, there will not be a return to 'normal', and patients and clinicians will have to adapt.

As part of the Covid recovery, the NHS can no longer have waiting rooms full of people ready to see their clinician in person. Some patients will 'come in' to be seen, but many consultations will be over video or by phone call. And – as pointed out in the phase 3 guidance – some secondary care services will operate patient-initiated follow-ups where



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appropriate, allowing the patient to decide when they need to see a clinician.

Like all trusts, East Lancashire Hospitals NHS Trust is planning to meet the phase 3 requirements. Director of finance Michelle Brown is the senior responsible officer for the trust's outpatient improvement programme, examining options as it seeks to restore services while taking account of the Covid-19 restrictions.

The trust is applying Lean methods – it is part of a national pilot on implementing Lean – as part of its improvement methodology. 'We have an opportunity to use this in an innovative way. The phase 3 guidance is quite a challenge and we are working through that now,' Ms Brown says.

Kate Atkinson, the trust's associate director of improvement, is overseeing the programme day-to-day and says the Covid pandemic has accelerated the trust's plans to introduce digital technology. 'We did things in weeks that we had been planning to potentially take years.'

The trust is using the Attend Anywhere platform for its digital consultations, and, pre-Covid, had planned to roll out similar technology gradually. 'Video appointments in physiotherapy and musculoskeletal are good examples of where the technology has worked well. The clinicians are able to demonstrate exercises to patients. Group consultations have also worked well,' Ms Atkinson says.

"You have to get the infrastructure right, ensuring people have the right equipment and access to the internet"
Rachel Hutchings, Nuffield Trust

The trust is currently reviewing the steps it took during the early phases of the pandemic in light of the phase 3 guidance, she says. 'It's really important to review things like virtual consultation, reflect on why we did it and ensure in the next phase it's about doing the right thing.'

Jane McNicholas, the trust's deputy medical director and breast surgeon, says the contract payment system has not always facilitated alternatives to face-to-face appointments.

'People wanted phone consultations for a long time, but bureaucracy and the payment system have been in the way – it's not that people think it's second best; they wanted to deliver outpatients in a different way and the coronavirus restrictions have enabled us to do that.'

Finance considerations

Ms Brown says the financial regime will have to consider the longer-term impact of the move to phone and video consultations to reinforce the changes. 'The initial actions on funding at the beginning of the pandemic did what was needed day to day, allowing us the flexibility to keep staff safe and patients out of hospital. We have concerns that, going

towards month 7, we don't yet know what the financial envelope will be, so that makes planning difficult. We are also concerned about the run rates being used to calculate any financial envelope, in that they may not reflect the future costs of living with Covid.'

Ms McNicholas adds: 'Not knowing if the finance will be available makes it difficult, especially if we are trying to work on a backlog, such as in endoscopy where funding is required to change the model or to pick up extra work.'

The Nuffield Trust's Ms Hutchings says the pandemic seems to have shifted clinicians' attitudes on the use of digital technology.

'Something has changed to make it acceptable and this can be seen in other countries too. In New Zealand, for example, it used to be the case that you could not prescribe a medicine unless you had physically seen the patient. The country has now changed that regulation.'

Patient acceptance will be key to the ongoing adoption of the technology – with or without the restrictions imposed by Covid. In July, a Healthwatch survey of patients showed they were largely happy with the move to video and phone consultations.

Teams players

As well as patient-facing technology, trust staff have widely and enthusiastically adopted Microsoft Teams. Ms Atkinson says: 'We had planned to roll it out as part of Office 365 from 1 April over a longer period, but with the need for social distancing and the number of people working from home, we were able to roll it out over a couple of days to about 10,000 users.'

Ms McNicholas says the Microsoft program has been a boon to the trust, allowing multidisciplinary teams (MDTs) to meet – the traditional approach of putting everyone in a room being out of the question.

"Teams has facilitated ongoing training for junior medical staff, including the recent induction for newly qualified doctors"
Kate Atkinson, East Lancashire Hospitals

'It's enabled us to continue with less risk. MDTs are a big part of cancer long-term planning and Teams has enabled lots of good working – I don't think we'll ever go back.'

She adds that it improves productivity – for example, patients' appointments can be accessed and booked during the MDT meeting while their cases are being discussed. Previously, these were booked by phone once the meeting was over. As a next step, putting the trust's planned electronic patient record in place would allow meetings to have seamless access to notes too.

Ms Atkinson points out other benefits – for example, it has facilitated ongoing training for junior medical staff, including the recent induction for newly qualified doctors. Managers do not have to move between sites for meetings, increasing attendance.

'We have used Teams to facilitate our business and we have evidence and feedback that it has improved productivity,' she says. 'Video calls have a downside in that you can't recreate the relationships with patients or colleagues that you get with face-to-face contact.'

Technology has helped finance staff do their work during the Covid outbreak, enabling many to work securely from home.

Christine Hall, associate programme director at NEP – the not-for-profit NHS consortium that offers integral finance and procurement services – says its cloud-based system has shown its worth during the pandemic. NEP took steps in mid-March, before lockdown, to support its own staff to work from home. 'We wanted to ensure business continuity so when lockdown came, we didn't encounter any interruptions to service,' says Ms Hall. 'At the same time, we took on a new client – Newcastle Hospitals – so we don't do things by half.'

Digital support

Pre-Covid, Northumbria Healthcare NHS Foundation Trust had been running small-scale trials of the Attend Anywhere video calling system, but when the pandemic hit it was able to scale it up quickly across different specialties for outpatients.

From April to July 2020 almost 55,000 – nearly 60% of all appointments – were non-face-to-face, compared with just over 10,000 (7%) in the same period 2018/19.

The trust has been an NHS Improvement pilot site for the system since summer 2019, but its strategy aims to do more digitally to help it cover its large catchment area. 'Some patients were travelling a long way for a five-minute consultation,' says Nicky Moon (pictured), deputy director of commissioning, contracting and strategic programme.

Now he wants to consolidate and enhance the steps the trust has taken during the pandemic.

'It is our strategy to reduce face-to-face consultations, and Covid focused everyone's attention. We want to continue to embrace that and we wouldn't want to go back to the old model of bringing everyone in.

'Some patients will need to be seen physically, particularly when delivering bad news, but there are opportunities where patients can have non-face-to-face consultations successfully.'

The trust's patient feedback shows a 96% satisfaction rate for non-face-to-face consultations. The shift to digital appointments has more than halved the average number of miles travelled per patient in two years to 7.2 miles. Other benefits include lower 'did not attend' rates.

The NHS phase 3 guidance asks for video and phone consultations to reach at least 25% as trusts get back to pre-Covid activity levels. 'It will be a blended approach,' Mr Moon says. 'We need to build up to pre-Covid levels, but the model has changed in terms of interactions with patients.

'We are working on a plan to increase our activity, making sure virtual consultations are part of that.'

He says the digital consultation targets in the phase 3 letter are ambitious and will be a stretch for some trusts. But he believes 25% is achievable for Northumbria Healthcare.

Outpatient appointments for maternity, psychological services (including child and adolescent mental health services and talking therapies), paediatrics and community services have been well-suited to the technology.

However, he says it may be more difficult to switch some of the more traditional specialties, such as cardiology, where physical examination may be required.

A small amount of funding (around £5,000) was given to the trust to begin the pilot – to buy hardware such as laptops, cameras and headsets – with NHS Improvement taking care of the Attend Anywhere licence costs.

Northumbria Healthcare has 91 waiting rooms in Attend Anywhere – each waiting room has a licence, with a cost attached (for NHS Improvement).

Mr Moon says: 'Not all rooms are being used continuously – 47 are used every day, but as we go forward, we will find out which ones we need.'

The East Lancs connection: (l-r) Michelle Brown, Jane McNicholas and Kate Atkinson

The consortium moved its finance and procurement systems to the Oracle cloud around 20 months ago. 'Without that transition from on-premises systems to the cloud we wouldn't have been able to support our organisations as much as we have been able to,' Ms Hall says.

'It's really come into its own during Covid. NEP includes general ledger, accounting to reporting, order to cash and purchase to pay. It has enabled accountants to manage their reports and submit accounts and returns.'

The NEP cloud is accessed securely via the internet, allowing access from anywhere, so working from home is so much easier. And the feedback has been positive.

'Staff feel that being able to work from home using our NEP cloud has enabled efficient flexibility, and we feel we have supported our NHS colleagues through no interruptions of service,' Ms Hall says.

She continues: 'Particularly when the NHS is under pressure to deliver frontline care, its ability to continue with business as usual with essential back-office services has just worked for us.'

NHS Shared Business Services (SBS) has also worked hard to ensure back-office staff can do their jobs from home. The joint venture between the Department of Health and Social Care and Sopra Steria provides services to almost two-thirds of the NHS, such as payroll, finance, IT and procurement.

At the start of the UK response to the pandemic, in fewer than two weeks it ensured almost all of its 1,500 UK employees could work from home. At the same time, it continued to process weekly and monthly payrolls for almost 400,000 employees in 90 NHS organisations with minimal interruption. Its payroll team accelerated the processing of new and returning NHS staff.

SBS adds that it supported the temporary funding mechanism set up at the beginning of the financial year, which moved the NHS in England to block contracts, and helped trusts enable home working.

Stephen Sutcliffe, SBS's director of finance and accounting, says: 'Our top priority since the outbreak of Covid-19 has been to safeguard our own workforce, while ensuring that NHS employees are paid, orders are processed, NHS suppliers are paid and cash continues to move around the NHS.

'Maintaining the level of support the NHS needs, whilst enabling homeworking on such a large scale, has required a monumental effort.'

Technology has always played a big role in NHS patient care and the diagnostic and monitoring equipment familiar in hospitals will be crucial in restoring services.

But the NHS will also need to continue to adopt new ways of communicating and working – not as ends in themselves, but as a way of facilitating the best care for patients.

clatterbridge

Glass act

The Clatterbridge Cancer Centre's new hospital in the centre of Liverpool will improve the quality of and access to services for the Cheshire and Merseyside population. Its design is eye-catching, but it also stands out as a major public sector construction success. Steve Brown reports

The Clatterbridge Cancer Centre NHS Foundation Trust recently pulled off a feat that is seldom seen in the public sector. In June, it opened its new £143m cancer hospital in the centre of Liverpool, broadly on budget and on time. And what's more, it opened the facility during the current Covid pandemic. In fact, it accelerated the final commissioning phase to bring the unit on stream to aid the region's response to the virus.

The new specialist hospital – which provides systemic anti-cancer therapies, including chemotherapy and gene therapy, as well as radiotherapy – is undeniably eye-catching.

The state-of-the art facility, which is completely clad in glass, is highly engineered and covers 11 floors. Its chemotherapy suite on the 10th floor offers floor-to-ceiling views of the city skyline, including its two cathedrals, and across the Mersey.

It has also been built using a mixture of public funding, borrowing, charitable donations and the trust's own surpluses.

No private finance model was considered for the project, despite the strategic outline case being approved in the same year that the (then new, now withdrawn) PF2 financing programme was introduced.

Finance director James Thomson says the success of the Clatterbridge programme owes a lot to the way the project was managed.

'One of the key points has been our wholly owned subsidiary, PropCare Services, which has managed the construction from the outset,' he says. The subsidiary, which was relatively unique when it was set up in 2016, has its own board and governance structure and has been able to focus on the hospital project. This has involved developing close relationships with contractors while keeping on top of all the necessary due diligence.

In fact, relationships between the trust and PropCare, and with main contractor Laing O'Rourke, subcontractors and facilities management providers, were a key part in the success of the project. 'Mutual trust was important,' says Mr Thomson. 'It was key that we could work our way through any obstacles together. There could be tough conversations, but we shared the same goal and had a similar mindset and ethos.

'I also think we have worked hard to effectively manage the risks of building the new hospital, with the subsidiary having the autonomy to make decisions but in a clear framework, which means all the big decisions are discussed and approved,' he continues.

'There have been pinch points along the way – such as changes in the commissioning landscape and how trust financial performance has been managed. But having a dedicated team in place with the right levels of skill has been really important.'

While the new centre does allow for expansion, it is really all about improving quality of, and access to, services.

The tertiary trust performs well – the Care Quality Commission rated it good overall in its 2019 inspection report. It was rated outstanding for 'caring' and the report said that inspectors were 'not concerned regarding the overall quality of cancer care'.

Challenges ahead

Yet despite this good general performance, the trust faces some significant challenges. Liverpool has some of the worst outcomes from cancer in England and cancer incidence across almost the whole of Cheshire and Merseyside is higher than the England average. There is a recognised issue with late cancer diagnosis, with more than one in five patients diagnosed through emergency care, which is often associated with poorer clinical outcomes.

There is also variation across the system, with people in the most deprived areas likely to have less healthy lifestyles and to engage less

with screening services. And this is against a context of overall rising incidence of cancer and associated increasing costs.

Some of these issues will need to be addressed as a system – Clatterbridge hosts the region's cancer alliance – but the new hospital will play its part in tackling others.

Location is important for the new hospital. The Liverpool site means the trust has moved its inpatient wards and services for rarer or more complex cancers over the Mersey from its Clatterbridge site on the Wirral. The Wirral site is towards the southern end of the Cheshire and Merseyside area. Opening a site in Liverpool moves services much closer for the 65% of the 2.4 million population served by the trust who live north of the river.

It also improves patient pathways and supports cross-boundary working. The cancer pathway spans primary care, secondary care (including acute and specialist providers in Liverpool), tertiary care and third sector bodies. The Liverpool location, which will be linked to the neighbouring new Royal Liverpool hospital when it opens, gives much greater opportunity to provide more integrated cancer care and will increase diagnostic capacity – one of the clear bottlenecks in existing pathways.

There is a safety angle too. Clatterbridge is relatively unique as one of only three specialist cancer trusts in the country and the only one not to undertake surgery. Given its size and range of services, it does not have intensive care or access to other clinical services such as cardiology or bowel surgery.

'The new facility allows us to co-locate our inpatient activity with the full set of services you get in a major acute trust,' says Fiona Jones, project director at the trust and managing director of the PropCare subsidiary. 'That was one of the main drivers for the new site.'

So, all the trust's inpatient beds have moved, slightly expanding the number to 110 – all provided as single, ensuite rooms. There is also a large non-chemotherapy day-case area with treatment couches and a clinical decision unit, where patients under treatment can be rapidly assessed – for example, when feeling treatment side effects – which helps the wider system avoid unnecessary admissions.

In general, Ms Jones says that while the centre may not be a major expansion on the previous facilities, it delivers new types of capacity. 'Previously, patients might have had to be treated in an inpatient bed because we didn't have bespoke facilities for day-case treatments,' says Ms Jones. 'But now, because we have greater segmentation – for example, for day-case and ambulatory care – people can be treated in a more appropriate setting.'

Its location next to a major teaching hospital and university is another major driver in enhancing opportunities to collaborate on research and development, making the organisation even more attractive to clinicians.

The project can trace its roots back to the Baker Cannon report in 2008, which recommended wide-ranging changes for the delivery of non-surgical oncology services across the area. Commissioners gave the new hospital the go-ahead in principle in 2012 and the outline business case was published in 2014. The design was approved in 2016 and construction began in 2017.

There were some short hold-ups in the overall timetable as the programme was reassessed in light of 2012's *Health and Social Care Act.* And the programme changed fundamentally part way through the process with the decision to move the haemato-oncology service, previously provided by the Royal Liverpool Hospital, to the Clatterbridge trust. This took effect in 2017 and the new hospital plans were revised to host the service once it was open. (The relocation of the service from the Royal Liverpool was expected to take place in September).

Financial preparations

The trust has also been preparing for the new hospital financially for several years. There was never an appetite to use the private finance model, with the trust leadership confident the £143m project could be funded from built-up surpluses, public dividend capital, loans and commissioner support.

With this capital goal in mind, the trust has delivered surpluses consistently in recent years – for example, achieving its 2019/20 control total of a £3.5m surplus.

This was based on a surplus after financing costs of £9m (the control total included subsidiaries and excluded donated asset depreciation). Surpluses for the previous three years averaged more than £8m and these have helped to create a healthy cash position.

The surpluses have been delivered from an income of £197m in 2019/20. Historically, the trust's financial position has benefited from underlying increases in cancer patient volumes and availability of new treatments such as immunotherapy.

However, 80% of clinical income comes from NHS England's specialist

"The new facility allows us to co-locate our inpatient activity with the full set of services you get in a major acute trust"

Fiona Jones, PropCare

commissioning team and this is now covered by a block contract. The remaining 20% has remained on tariff, but with caps and collars in place to share risk with key CCG commissioners.

Plans agreed for 2020/21 have not been implemented following the outbreak of the Covid-19 pandemic, with the whole of the NHS in England being moved to block contracting arrangements.

Some £72m of the total capital spend has been provided to the trust through public dividend capital (£35m) and a loan (£37m) from the Foundation Trust Financing Facility.

A further £11m comes from charitable donations. And the balance is made up from trust surpluses and contributions from the local economy and specialist commissioning.

Operating costs have gone up. Depreciation has increased by £4.5m and there are extra facilities costs of £4.8m.

In addition, a further £3.7m investment in workforce has been planned, adding an extra 136 whole-time equivalents to the previous 1,100 strong staff. These costs will be offset by increased income relating to the higher bed count and the repatriation of some acute oncology activity from across Cheshire and Merseyside.

The surpluses generated in recent years will also reduce as a consequence – the £3.5m surplus in 2019/20 was planned to reduce to £445,000 this year.

'The trust has been flexible in its approach,' says Mr Thomson. 'We set off with a clear programme where we knew what we wanted to do and we had a good way of delivering that. It has been well worked within the rules of the system at each stage.'

Associate director of finance John Andrews, who has been at the trust since the project was launched, says relationships with key stakeholders also worked well.

'Working with partners locally – whether that is CCGs or specialised commissioning and their forbears and the NHS Trust Development Authority, Monitor and NHS Improvement – there's been support,' he says.

'And in terms of financing it, we are providing a service that has experienced increasing demand year on year, and it is expected to recover from the reduction in referrals because of the Covid outbreak.'

"We are just starting on a benefits realisation programme to make sure we are getting everything we can out of the new building"

James Thomson, The Clatterbridge Cancer Centre

Covid role

The new hospital opened at the end of June with the country and the NHS still gripped by Covid-19. Clatterbridge has not been providing any frontline Covid treatment as part of the overall NHS response, but it has had to rethink its service provision for its patients, who are among the most at risk from the virus.

Around 80% of follow-up appointments were being done virtually at one point and clinicians are now listening to patient feedback and reviewing how innovations introduced during the pandemic will inform optimal delivery of services in the future.

Opening the hospital during the coronavirus crisis might seem like an additional challenge, but the trust regarded it as a way to help. The hospital's single rooms and clean air technology – with no A&E to create potential cross-contamination – were seen as assets in the current context.

'We had some interesting conversations with our contractor, Laing O'Rourke, and worked out how we could ensure that we opened on time despite the impact of Covid-19 on construction sites – reducing a three-month commissioning period to four weeks and accelerating the build,' says Ms Jones.

The Wirral remains an important part of the overall equation, albeit being used in a different way and with no inpatient beds. It is also subject to an upgrade programme to create an ambulatory care village. And the trust will continue to provide radiotherapy services in a satellite centre in Aintree.

But there is no doubt that the new Liverpool hospital is the flagship in the trust's estate.

'We are just starting on a benefits realisation programme,' says Mr Thomson, 'to make sure we are getting everything we can out of the new building.'

This exercise will be particularly important as the hospital looks to work with the wider system to improve cancer outcomes.

'The hospital provides a great place to work and will facilitate more cancer research,' concludes Mr Thomson. 'But it will also make it easier to transform the clinical model – creating a hub for specialist work and providing a hub-and-spoke model for less acute patients.'

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Collective response

Covid-19 has provided challenges for collaboration between clinical and finance staff, but it also led to positive changes. A virtual roundtable in September looked at the importance of continued joint working as the NHS rebuilds post-virus. Steve Brown reports

The NHS is no stranger to calls for closer working between clinicians and finance professionals. However, the Covid-19 pandemic has increased the importance of collaboration as the service looks to capture permanently some of the new ways of working put in place.

A recent virtual roundtable organised jointly by the HFMA and the Faculty of Medical Leadership and Management (FMLM), in association with Future-Focused Finance (FFF), set out to explore how clinicians and finance can work together to build a new, stronger NHS post-Covid.

Roundtable chair Su Rollason, chief finance officer at University Hospitals Coventry and Warwickshire NHS Trust, asked the clinicians and finance managers taking part to describe how well clinicians and finance professionals were working together before Covid.

There were plenty of examples of good practice, but also a concern that engagement differed from team to team and from organisation to organisation. And engagement across whole systems could be improved.

GP and West Hampshire Clinical Commissioning Group chair Sarah Schofield said the creation of clinically led CCGs had catapulted GPs into the position of taking decisions about major budgets. 'We were thrown into a financial environment very quickly where we had to address financial decisions that had huge impacts on our population,' she said. 'It was fundamental to the set-up of CCGs that clinicians had to work very closely with finance. I have learnt a lot from them, but it requires a clinical mindset that values that experience as much as clinical experience. There is a lot to be gained from both parties.'

Madi Parmar, director of contracting at University Hospitals Birmingham NHS Foundation Trust, said the historic perception by clinicians of finance staff being preoccupied with money and not appreciating quality still prevailed in some areas. But she also suggested that clinicians can have a fear of finance.

'Some clinicians have suggested they don't like to be ill-informed and this can lead to them not getting involved in the finance business arena,' she said. 'So there is an important role for finance colleagues to remove this fear and ensure we are sharing finance information in a very accessible way. Engaging and using a common language is really important – it might be something as simple as pictures not pivot tables.'

Tools and approaches such as service line management have helped to foster joint working around service improvement in some organisations.

Tim Yates, neurology registrar and chief medical information officer at the Royal Free London NHS Foundation Trust, said his trust's system had seen some success. 'Where this works, it works tremendously well. For example, the management and costs around our therapy services were hugely improved by a clinician getting to grips with the service's finances,' he said. 'But that only works where the clinician takes the time to understand how to read the financial reports and then engages with that. Where that hasn't happened, the service line management process is unsuccessful.'

Dr Yates suggested there is still a tendency for clinicians to see finance as a function to restrict their opportunities for innovation. And he said

Top (l-r): Sarah Schofield, AK Maheswaran, Ros Preen
Centre: Madi Parmar, John Devapriam, Jenny Ehrhardt
Bottom: Su Rollason, Kate Langford, John Graham

HFMA-FMLM ROUND TABLE

Participants

- Paul Buss, Powys Teaching Health Board
- John Devapriam, Worcestershire Health and Care NHS Trust
- Jenny Ehrhardt, Manchester University NHS FT
- John Graham, Stockport NHS FT
- Kate Langford, NHS England
- AK Maheswaran, University Hospitals of Leicester NHS Trust
- Madi Parmar, University Hospitals Birmingham NHS FT
- Ros Preen, Shropshire Community Health NHS Trust
- Chair: Su Rollason, University Hospitals Coventry and Warwickshire NHS Trust
- Sarah Schofield, West Hampshire CCG
- Tim Yates, Royal Free London NHS FT

this was reinforced if improvements or innovations by service lines didn't lead to opportunities to invest in that service.

Paul Buss, director of clinical strategy and interim medical director at Powys Teaching Health Board, said he had seen a sea-change in clinical-financial engagement in the past five years. 'Twenty years ago, clinicians saw finance managers as knowing the cost of everything and the value of nothing, but now I see really good relationships developing,' he said.

'Finance is an incredible reflector of behaviours in our system. So when you look at the money, you see the clinical behaviours and comparative differences between organisations. For me, it is finance data that raises all the really interesting questions and I think the dialogue has changed. There is less fear now in conversations between finance and clinicians and there should be more expectation of these conversations happening. It should just be the norm in a modern healthcare system.'

Consultant anaesthetist at University Hospitals of Leicester NHS Trust and FFF clinical engagement lead AK Maheswaran agreed that the perception of finance had changed in recent years. 'When I first got involved with FFF about five years ago, there was definitely a perception among clinicians that finance colleagues were barriers to what they were trying to achieve. But as I engaged with finance professionals, I found they were very keen to engage but often didn't know how to.'

And 'finance for clinician' sessions over the past few years have shown there is a real appetite for finance knowledge among clinicians – particularly at the new consultant and senior registrar level. Again, the issue is with knowing how to engage and finding a common language.

Dr Maheswaran also believes there is an 'obsession with business cases and income generation', with clinicians feeling they have to know how they are going to make more money rather than focusing on quality or the broader system impact of new ways of working.

Ros Preen, director of strategy and finance at Shropshire Community Health NHS Trust, said it was great to hear about the positive examples of good engagement that were supported by tools such as service line reporting or patient-level costing. 'But it is not a level playing field,' she said. 'Some of these tools make these conversations easier – but we should remember there are parts of the NHS where service line management information doesn't exist. And those conversations have to be formed in a different way in order to support change – you have to be creative and use what you've got at your disposal.'

Covid impact

The Covid-19 pandemic has provided major challenges for the NHS, with a significant burden put on frontline staff. Many clinicians were redeployed as the service put a huge amount of focus on treating patients with the virus, while running other core services in a Covid-secure way.

Support functions, including finance, have also faced major upheaval. Again, staff have often been redeployed to support the supply of personal protective equipment or to help the frontline effort in other ways. And many finance departments have moved wholesale to homeworking.

This has had both negative and positive impacts on ongoing joint working. Regular interaction between finance, clinicians and operational managers on budget management has reduced as financial considerations became less of a priority. Ongoing and year-end engagement over costing data was also put on hold as normal summer costing deadlines were pushed back until the end of the year. But in other ways, the pandemic has enhanced collaboration.

Ms Parmar said that, in the early stages, some sections of the wider finance team became much more visible to the rest of the organisation than normal. Procurement staff, for example, were working seven-day shifts to ensure PPE was procured and moved around healthcare sites to where it was needed.

'It was the same with payroll,' she said. 'Setting up the Nightingale hospital in Birmingham, we had to get thousands of payroll changes implemented in a few weeks, such as medical rota changes and putting temporary bank staff and student nurses onto the payroll very quickly. This shone a light on back-office areas of finance and we became a bit more visible to the organisation in terms of what we contribute, including finance staff repurposed from other teams.'

The contracting function was also able to use project management, analysis and diplomacy skills to broker new pathways – for example, for direct access imaging and to support the rapid adoption of a confer-before-refer model in outpatients. Finance staff were able to facilitate

"There is an important role for finance colleagues to ensure we are sharing finance information in a very accessible way, engaging and using a common language"

Madi Parmar, University Hospitals Birmingham NHS FT

discussions, manage queries and set up reporting mechanisms to ensure new pathways were working as intended, Ms Parmar said.

'We managed and supported the clinical primary and secondary care interface, talking to clinical teams and GPs, ensuring good communications, troubleshooting and providing information. Working as a close team from the start has helped to break down a lot of barriers.'

John Graham, finance director at Stockport NHS Foundation Trust, agreed that some of the redeployment of finance and procurement staff had really helped to mix people in together. 'It gave people a chance to appreciate each other's roles, whereas before there was perhaps a tendency to just go about doing your job and we didn't get the interaction with clinical colleagues.'

Changing the governance arrangements also helped, he added. 'We stood down a lot of our formal board committees and set up clinical, workforce and financial advisory groups. In the early days, these were meeting daily. We were presented with some great ideas and were able to turn these around really quickly. That positive outcome helped, as a I think clinicians started to see us as enablers and facilitators. The challenge is how we keep some of that going on.'

John Devapriam, medical director at Worcestershire Health and Care NHS Trust, said he had found Covid to be a good experience in terms of collaborative working, building on the trust's focus on quality and sustainability in recent years. 'We had to act quickly and clinicians got together to look at the best things to do in terms of clinical pathways and services. And finance colleagues corralled around us to support us. Trust was a key issue.'

However, he said, while he experienced clinicians getting together across systems to think through how pathways worked across organisational boundaries, it would be good to see clinicians and finance all collaborating at the system level.

Fundamental questions

Dr Buss believed Covid was asking fundamental questions about finance and the model for delivering services. 'We threw a lot of money at what was an old hospital model out of necessity,' he said. 'But now we are reflecting about the potential of digital working and how we can look after patients very differently.

'If you follow the money at the moment, it is invested in the hospital, but the really big challenges in the next 10 to 15 years post-Covid are going to be diabetes and dementia. And the model is going to be a social, primary care and mental health one.' He said clinicians and finance would need to work together to make this transition.

Ms Parmar said one of the key roles of finance leaders was to navigate some of the tricky issues. 'One of the issues thrown up for us has been around phlebotomy, where we have separate primary care and secondary care phlebotomy services,' she said. 'What we are reflecting on now is whether we can have a system phlebotomy service that is primary and secondary care agnostic.

'The challenge, as system finance leaders, is to find a way to pool our resources for phlebotomy and thereby help to design a service where it doesn't matter who the patient is referred by – removing the obstacle to further effective clinical pathway change. Sometimes it is these small issues that can derail some of the bigger things we want to do around transformation.'

Kate Langford, medical director for systems improvement and professional standards for NHS England's South East region, said a big difference she observed during Covid was the way it gave people courage to do things without waiting for formal permission. 'The move to virtual outpatients was a good example of that,' she said. 'We've been trying to make the move for a really long time, but everyone could always think of one more thing that might go wrong. Suddenly it became a necessity and we did it. And we got through the teething problems and it worked. That shift has brought together colleagues from clinical areas and finance.'

Dr Langford acknowledged that the temporary financial regime – with money not allowed to be an obstacle to the frontline response – facilitated this. 'But it is those relationships that we now need to build on and nurture because we finally got people in the same room talking in a "let's do this and then sort out the problems"-type of way,' she said. 'That was really very healthy.'

HFMA-FMLM ROUND TABLE

Ms Preen said the command and control approach taken to support the response to Covid at system level had helped with rapid decision-making. Lessons should be learnt for the way sustainability and transformation partnerships go about business in future. But she said the service has also benefited from having a real clarity of purpose. Systems and solutions were put in place because the funding was secure. Also solutions such as digital systems had national backing, due diligence had been done once and organisations could just deploy. She said there was a real danger that processes would slow down again as finances re-tighten and the service returns to local decision-making.

Dr Maheswaran said that in Leicester, a lot of clinical engagement around costing had been disrupted by Covid and effort was needed to get this going again. But virtual meetings had enhanced engagement in other areas, enabling clinicians to take part in meetings they previously wouldn't have attended. 'Often, to attend meetings, I lose at least half a day of clinical time to factor in travelling,' he said. 'Now I can arrange cover for 30 minutes or an hour and attend from within the operating theatre complex, where I can easily be reached if any problems arise.'

Jenny Ehrhardt, group chief finance officer at Manchester University NHS Foundation Trust and FMLM treasurer, underlined concerns about the impact that uncertainty – over what comes after the temporary finance regime – might have on engagement. 'As we think about recovery, there is a frustration that we don't yet know what the money will look like in the next half of the financial year,' she said, 'and that's been a hindrance in terms of decision-making, which then has a negative impact on engagement.'

Participants expressed concerns about falling back into old habits or previous ways of working, both in terms of frontline services and governance arrangements.

There is an understandable focus on the waiting list backlog and the resources that might be needed to address this. But Dr Buss said the service should avoid traditional responses. 'We need to resist going back to the same old. We've got to resist moves to just having more people – particularly doctors – and be talking about how we can have more differently. I think that is one of the things we've learnt from Covid. We want more different things. And the challenge from clinicians back to finance should be that we don't want a blanket approach.'

But Mr Graham was concerned about existing staff. Frontline and support staff had worked hard and in stressful circumstances. 'How do we keep that resilience going and how do we support people?' he asked.

"We don't yet know what the money will look like in the next half of the year – and that's been a hindrance in terms of decision-making, which has an impact on engagement"

Jenny Ehrhardt, Manchester University NHS FT

Top: Ros Preen and Sarah Schofield
Bottom: Su Rollason and Tim Yates

Ms Parmar also warned that the 'pendulum was swinging back on reporting' as the service moved into phase three of the response. 'There is a danger that we will get swamped with multiple rapid turnaround template returns resulting in a disconnect between "back-office" finance and the real redesign work that is going on at the coalface, which does not lead to accurate modelling and is not a good outcome for anyone.'

Dr Langford stressed the importance of finance staff helping clinicians to understand the financial changes accompanying the move to phase 3.

'I would love to see people capitalising on the new-found personal relationships formed through Covid to explain to clinicians about the reporting requirements and the new rules around financial flows.'

Participants were asked what they wanted to happen to improve joint working in future. Several participants said the tariff system should not be reintroduced, with the old payment by results approach creating perverse incentives. For example, moving to new ways of delivering outpatient appointments could lead to a loss of income for the provider.

However, Dr Schofield said payment systems could be used to good effect to improve population outcomes. In the US, for example, she said reducing payments for Caesarean section had incentivised a health system to invest earlier in the pathway to improve the health of young women and new-born birth weights across the system.

Dr Langford said the clinical and financial focus must to be on pathways. Ms Preen agreed and called for an emphasis on system-based costs along the pathway – to support a better understanding of resources consumed in providing care – rather than income. NHS England and NHS Improvement had already started to move away from the tariff system before introducing the temporary block contract approach during Covid. But there are increasing calls for faster adoption of aligned incentive-type contracts or moves to population health budgets.

Dr Buss would like to see a chief value officer appointed by all providers overseeing a move to integrated reporting – a medical director or assistant director who would work closely with finance to educate all staff on the importance of value-based healthcare.

Dr Maheswaran said it would be important to be able to explain the system simply to clinicians and avoid unintended consequences. It would be a backwards step if the move away from payment by results led to a reduced focus on clinical coding. He said there were big opportunities to improve value by moving investment earlier in the pathway, but clinicians needed support from finance teams to make this happen.

Summing up, chair Su Rollason said the challenges and changes forced by Covid presented an opportunity to change the way clinical and financial professions work together.

'We need to capitalise on this,' she said. The improved visibility of finance should be maintained. And the two disciplines should continue to implement change at pace, building on some of the successes achieved during the initial Covid response.

"The burden on finance staff in terms of reporting seems enormous... It was great that we were able to throw those shackles off briefly"

Tim Yates, Royal Free London NHS FT

In general, there were calls for finance to get more involved with workforce issues and to create better links between workforce and financial planning – with finance staff working with clinicians to understand the costs and benefits of new roles.

Ms Ehrhardt called for a pragmatic approach to prioritising service change. 'Every service is looking to build back better and there is an issue with the sheer scale,' she said. 'Will finance and operational teams have the capacity to respond to all the change that is important to individual clinicians? There is a risk that we don't do anything because we can't get our heads around all of it. It would be better to do some things really well than to do everything thinly.'

Governance changes

Some reporting requirements were also relaxed during Covid – while new daily sitreps were introduced to provide a national view of the infection's spread and impact. But overall there was a feeling the focus was on acting and doing rather than reporting. Dr Devapriam said direct virtual conversations between clinicians and finance enabled agreements to be made outside of the usual bureaucratic arrangements. 'We need to look at how we can continue some of this,' he said. 'So if there was a clinical idea on how to implement something, you could have a conversation with finance and implement and test it without going through all the approval and business case processes. It needs to be about rapid implementation and real-time learning.'

Dr Yates echoed this. 'The burden on finance staff in terms of reporting seems enormous and that gets in the way of dialogue with clinicians and the ability to focus on other things,' he said. 'It was great that we were able to throw those shackles off briefly.'

Having access to finance staff at the Royal Free had worked well, he said, and organisations that had chosen to offsite their back-office functions might want to think about the implications for future engagement with clinicians.

hfma
professional lives
Events, people and support for finance practitioners

Treasury proposes full refund model as preferred option for VAT simplification

Technical

In his March 2019 Spring Statement, former Chancellor Philip Hammond said the Treasury would publish its policy paper on VAT simplification, *writes Debbie Paterson*. That paper has now been published.

The paper sets out the Treasury's proposal to move to a full refund model for those public sector bodies, including all NHS bodies, that are subject to section 41 of the *VAT Act 1994* (s41). This will broadly align the treatment of VAT for central government departments, Highways England, as well as NHS bodies in all four nations, with that for local authorities.

Currently, only VAT incurred on services on the list of contracted-out services (COS) headings can be recovered by bodies subject to s41. The proposed full refund model will extend the scope of s41 to permit full refunds of VAT incurred on all goods and services purchased during the course of non-business activities.

It is intended that this proposal will remove barriers to working with central government and NHS bodies for businesses, charities and local authorities and, therefore, reduce the risk of entering into new working arrangements.

The simplified arrangements should also reduce the need for advice from external consultants and/or HMRC.

It is hoped this will result in speedier business case and budget development for new ways of working. And the focus of proposals should be on service delivery rather than the VAT implications of the new working arrangements.

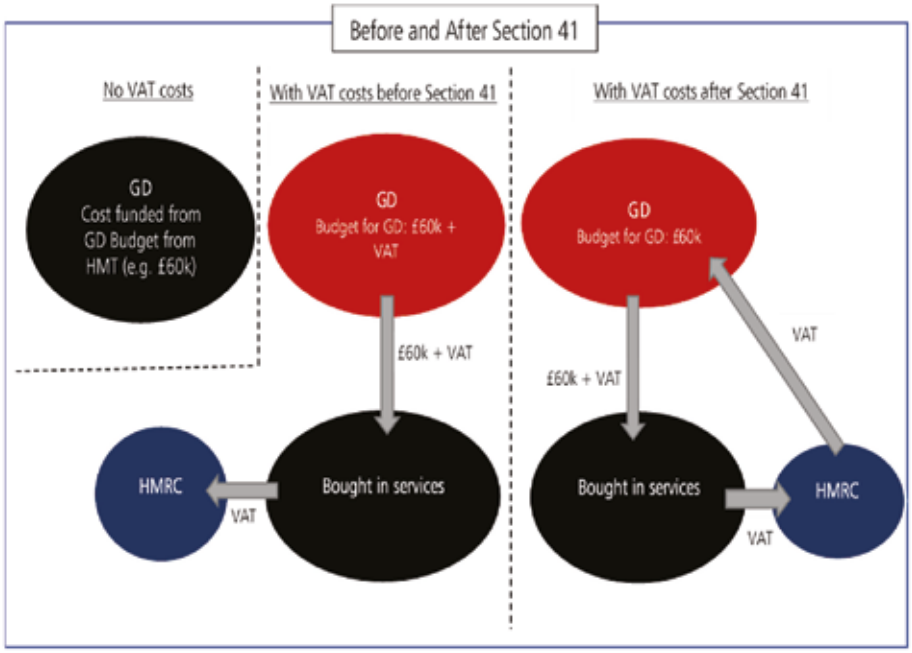
Simplification should also reduce the number of queries raised and errors made when invoices are processed – reducing the resource currently employed by management and HMRC to answer queries and identify and correct errors.

The government has made it clear that any proposed changes must be fiscally neutral, »

Taking soundings

The proposal document specifically seeks views relating to:

- The proposed full refund model or any alternative models
- The complexity of implementing the reforms
- The nature and scale of the administrative burden of the current COS arrangements for public sector bodies
- The impact of the current s41 rules on businesses interacting with central government and NHS bodies and the merits of the proposed reform
- Whether the proposed reform provides benefits to productivity and organisational structuring
- Whether the current system requires legal and tax professional resource to resolve disputes and whether that resource will not be required under the proposed simplified system
- The impact the proposal could have on ensuring that the UK is an attractive place for business and enterprise
- The appropriate timing, methodology and associated costs for implementation – particularly the impact on accounting systems and contracts with external service providers.



Source: HM Treasury, *VAT and public bodies*

» so these proposals will affect allocations voted to government departments. Currently, departmental expenditure limits (DELs) include funding for VAT that cannot be recovered.

However, recoverable VAT is processed through annually managed expenditure (AME). These proposals will automatically affect AME as they relate to recoverable VAT so an equal and opposite adjustment will have to be made to DEL budgets to ensure the proposal will be fiscally neutral. Adjustments to DEL will have a knock-on effect on the Barnett formula for the devolved nations, so their views are sought on this specific issue.

The data to assess the impact of the proposals on budgets is not readily available so the Treasury has started to gather the data necessary to establish the scale of any budget adjustments. There will be further information on this collection process in due course. NHS bodies will recall that there was a data collection following the March 2019 announcement – there are likely to be further such requests although the paper is clear that no changes will be implemented until the ongoing Covid-19 crisis eases.

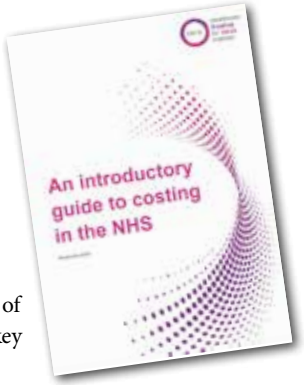
The policy paper is not a consultation document, but the Treasury is asking for views on it by 19 November. There are no specific consultation questions as the government is interested in any reactions or comments from interested stakeholders. This could include NHS bodies and their subsidiaries, those who work with NHS bodies, suppliers of goods and services and suppliers of VAT and tax advice.

Debbie Paterson is HFMA policy and technical manager

Technical review

Technical

A total of 27 acute providers have been asked to submit costs for the first quarter of 2020/21 to help improve understanding about the impact of Covid-19 on the costs of patient care. NHS England and NHS Improvement announced the **exceptional quarterly collection** (EQC) in August and, if it proves successful, the organisations plan to collect costs for the remaining quarters at later dates. The data will be used to analyse the extent of the change in cost profile caused by the pandemic – both on Covid and non-Covid patients. Any trusts taking part may be able to move their National Cost Collection submission date if required. Where possible, the EQC template will be pre-populated with data for trusts to verify and the basis of submissions does not need to be Costing Transformation Programme-compliant. Trusts will submit aggregate data – not patient-level cost data – for A&E, admitted and non-admitted care, rehabilitation and critical care, profiled by fixed, semi-fixed and variable. Any other trusts keen to get involved in this collection are asked to contact: **nhsi.eqc@nhs.net**



The HFMA Healthcare Costing for Value Institute has published an updated version of the ***Introductory guide to costing in the NHS***. The guide, which is available for download by institute members, describes the fundamental elements of the costing role and highlights sources of further support and information. It provides an overview of the importance of costing, as well as the key steps involved in driving patient-level cost data. In addition, the guide sets out a typical patient-level costing cycle for costing practitioners. **hfma.to/sep203**

A new version of ***Who pays?*** has been released by NHS England. The document, which was last published back in 2013, sets out the framework for establishing which NHS commissioner is responsible for commissioning and paying for an individual's care. The new document pulls together previous separate addenda and explanatory notes into a single source. It also takes account of the discharge to assess arrangements set out in *Hospital discharge service: policy and operating model*, which was published in August. And it sets out a mandatory dispute resolution process. **hfma.to/sep201**

Guidance on the use of **agency staff** during Covid-19 was updated at the beginning of August. It includes a suggested interpretation of *PPN (procurement policy notice) 02/20* – and the provisions of PPN 04/20 – regarding the payment of 'at risk' providers. It sets out the circumstances where bank or agency workers affected by Covid-19 should receive full or partial pay. The guidance also emphasises the need for agency spending to remain on-framework, with alleged profiteering reported to NHS England and NHS Improvement. **hfma.to/sep202**

New ways set out to gain masters-level qualification

By Alison Myles, HFMA director of education

Training

The HFMA is introducing more flexible studying arrangements to achieve its masters-level diplomas in healthcare business and finance.

The association is keen to remove any barriers to studying for its advanced qualifications, which provide a route through to studying for an MBA in healthcare finance, awarded by BPP University. One of these perceived barriers is the time commitment involved over a sustained period combined with specific milestones and diary events.

For example, a student signing up to either the advanced diploma or higher diploma faces a fixed timetable for each module lasting 17 weeks. This includes weekly live sessions with a module tutor and an assessment.

This provides students with the potential to complete three modules in a year and so achieve the diploma with one year's study.

However, not everyone feels able to commit to such a structured programme. So the association has added a new additional route to achieving its diploma, enabling students to match their studies to their own preferences.

Students would still sign-up to three modules for either the advanced diploma or higher diploma. However, they could study at their own pace. There would still be a finite window within which they would have to finish their studies, but students could work much more at their own pace, choosing when to start studying and how long to take for each module.

And with the self-study approach, they could choose from three assessment windows rather than work towards fixed assessment windows for each module.

The two approaches – self-study or tutor-led – both draw on the same content, although the self-study route uses materials from the HFMA bitesize courses and there are differences in the assignments that students have to complete.

However, self-study students will be able to switch to the tutor-led programme if they subsequently decide that this provides a better match to their studying style.

Alternatively, those wanting to take even smaller steps towards the qualifications can study individual HFMA bitesize courses. Once all the courses have been studied within a diploma module, students could then purchase an assessment.

The aim is to provide a range of different ways for people to access the qualifications. Once students have gained the advanced higher diploma, they are eligible to sign up for the MBA in healthcare finance.

The first seven graduates from this programme gained their MBAs earlier this year and a further eight students are on track to complete the course by the end of the year.

• For more about HFMA qualifications visit www.hfma.org.uk/qualifications/

Student success

Nineteen learners completed advanced modules in the May assessment, having started their various modules in January. This represented an impressive 86% pass rate, with two learners achieving a merit and one receiving a distinction.

There was high level of deferrals as learners' ability to study was affected by the NHS response to the Covid-19 pandemic, with work pressures an issue for several on the programme.

The submissions were spread across six modules, including deferred submissions from previous intakes, with four modules run in the first half of the year. The module on comparative health systems attracted the most students in the January intake.

A new batch of learners began a module this month, with applications up 25% compared with January.

Value maker annual conference goes virtual

Future focused finance

The value maker annual conference is the highlight of the Future-Focused Finance calendar and despite not being able to meet face to face this year, the virtual event promises to be an exciting afternoon, with hundreds of delegates signed up.

On **24 September** value maker senior responsible officer Suzanne Robinson (pictured) will appear live from The Studio for an afternoon of celebrating the hard work of finance teams during the pandemic; showcasing examples of best practice from a range of organisations; and recognising the achievements of individuals in the second value maker awards ceremony.

The interactive event will involve two panel sessions. The first will focus on ways of improving the things that matter most, using the opportunities a post-Covid and Black Lives Matter world presents. The second will celebrate successes through Covid-19 and beyond, with a chance to hear from NHS staff in a wide range of roles.

The network has grown to more than 2,000 during this unprecedented period. 'It has been a challenging year and to have access to thousands of people across the NHS to talk to, share ideas and support each other has proved an invaluable resource to our finance staff across the NHS in England,' Ms Robinson says. 'This virtual conference offers an opportunity to celebrate our strong network and develop it further.'

The conference is open to all value makers, as well as those wanting to find out more about joining this network of NHS finance champions.

For further information on the conference or the awards, please contact **futurefocusedfinance@nhs.net**

Diary

September

16 (I) Institute: introduction to costing in the NHS, online
17 (B) South West: virtual annual conference
18 (W) Governance and control in a virtual working-from-home environment, 1.30pm
21-25 (B) Wales: virtual annual conference
29-30 (H) Provider, Commissioning, Mental Health and System Finance networks: professional development summit, online

October

9 (B) Kent, Surrey and Sussex: virtual annual conference
19-23 (B) West Midlands: virtual annual conference, Festival of finance
21 (H) Charitable funds, online
22 (I) Institute: value masterclass: value and Covid-19, online
29-30 (B) Scotland: virtual annual conference

November

5 (H) Estates and facilities forum, online
9 (I) Institute: costing conference, online
11 (H) NHS Leadership and CEO Network: forum, online
12 (H) Commissioning Network: implementing NHS strategy – the commissioning perspective, online
30 (N) HFMA annual conference, hybrid event

January

12 (H) Chair, Non-Executive and Lay Member Network: chairs conference, online
19 (H) Mental Health, Commissioning and Provider networks: CFO and directors' forum and lunch, London
20 (I) Institute: introduction to costing in the NHS, online
21 (B) Yorkshire and Humber: annual conference

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

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

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Events in focus

Costing conference
9 November, online

The 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 harness the power of data. The day will feature interactive workshops, case studies, policy updates and online networking.

Speakers include the 2019 HFMA Costing Award winners Gloucestershire Health and Care NHS Foundation Trust, and there will be a national update from the NHS England and NHS Improvement costing team.

This event provides a crucial opportunity to raise the profile of costing in your organisation and health economy. The day has been designed for costing professionals and those not in a costing role but with a part to play in the costing agenda. It is a must-attend for those who wish to develop a network of support and gain confidence to meet costing requirements.

The 2020 costing conference has been moved from April to November due to Covid-19, and all booked delegate places have been automatically transferred. It will take place online.

• **To find out more or book, email** institute@hfma.org.uk

HFMA annual conference
The 12 days of conference: a festival of learning
30 November to 11 December, online

In an exceptional year, this will be an event like no other from the HFMA. And although face-to-face contact is limited by Covid restrictions, this virtual conference will still bring finance staff together and allow for networking.

Indeed, the programme has been designed to ensure the association can reach out to more finance team members, of all levels and experience, than ever before. Every place purchased helps the association to represent and support health and social care finance professionals by influencing health and social care policy, promoting best practice and providing high-quality continuing professional development and education.

Led by HFMA president Caroline Clarke (pictured), the conference will begin with reflections on the NHS finance role during the Covid-19 pandemic and move to a focus on the future with patient-centred technology, innovation opportunities and how the service will move forward with financial recovery. Further details of the event will be published on the HFMA website in the coming weeks.

• **To book, email** josie.baskerville@hfma.org.uk

The 12 days of conference

Association view from Mark Knight, HFMA chief executive

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

My HFMA

What an extraordinary six months we've been through. When we reflect on the Covid-19 outbreak in future, we will probably regard it as a turning point in our history as a country and for us personally. For now, we are still in the middle of a crisis, which, although the severity may have reduced in some areas, is still very much with us.

During the pandemic, you will have been aware of the considerable output of HFMA policy and technical director Emma Knowles and her team. Much of this relates to Covid-19, including the regularly updated *Covid-19 guidance map*. For further details go to **www.hfma.org.uk/our-work/covid-19**.

Alongside this, the editorial team have recreated a new service, *Healthcare Finance weekly*, emailed to you every Friday. If you aren't getting your copy, contact **membership@hfma.org.uk**. It has proved popular – keeping pace with a fast-changing agenda and helping to keep the finance function together when most people were working from home.

That weekly bulletin is here to stay and the print magazine – which will now be published quarterly – will complement this news service, with more in-depth features and analysis.

The current crisis has hit the HFMA hard, with a deficit of about £750,000 for the year ending June 2020. We are working to a much-restricted budget for 2020/21, having regrettably lost 16 of our staff through redundancy and the rest having taken a temporary pay cut.

We continue to provide members with the very best services we can and I've been impressed with HFMA staff's adaptability and their knack for thinking outside the box.

However, by far our biggest challenge is still ahead of us. You won't be surprised to hear that we have had to cancel our normal visit to the London Hilton Metropole for this year's annual conference. But I'm delighted to announce that we will be running our event virtually this year. The '12 days of conference' will be just that – a feast of online content for 12 consecutive days between Monday 30 November and Friday 11 December. Don't worry, if you can't catch it all live, you will be able to login at any point over the following 30 days to reprise the content.

HFMA chief executive Mark Knight

The conference is still being finalised, but expect workshop-style webinars and 'main stage' presentations and keynotes. One day will be curated by Future-Focused Finance. There will be a student day. And there will be service updates and motivational sessions – just as at the usual conference, something for everyone.

Most of the conference will take place in the afternoons and the pricing will be per organisation as the event is for the whole function, not for just the top echelons.

It will feature three of the usual stalwarts of the annual conference – there will be a prize draw, free to enter as always; it will feature the annual general meeting; and the HFMA Awards ceremony will be held on 10 December.

It has been a momentous year for the NHS and the finance function has played a significant part. It is right that the function should get together to share best practice, find inspiration and celebrate the best that finance has to offer.

And on the subject of the awards, the closing date is 2 October. There's still time – and you've got to be in it, to win it! See you online soon…

Member news

The HFMA honoured 18 members in August for their contribution to the association. Among them, Andy Ray and Simon Crowther received **outstanding contribution awards** for achievements such as undertaking research or organising an event. Recipients win a voucher they can use on an HFMA programme or a contribution towards a study tour. Mr Ray, nominated by the Eastern Branch, has promoted the use of the HFMA for personal development, and played a major role in the 2019 branch conference. Mr Crowther spent six years as East Midlands Branch chair, stepping down in 2019 to be a trustee of the association. He reinvigorated the branch annual conference and built strong links with Future-Focused Finance and the Skills Development Network.

- For a full list of the honours, go to **hfma.to/59v**

The **Eastern Branch** committee has two new members from Hertfordshire Community NHS Trust – director of finance David Bacon and deputy director James Thirgood.

HFMA branches due to hold annual conferences this autumn have moved the events online:

- **South Central Branch** will host an online conference, with an awards ceremony and sessions on 'pride in the NHS'
- A week-long **HFMA Wales and ACCA** annual conference will have three sessions a day, with speakers including Andrew Goodall, NHS Wales chief executive
- The **South West Branch** conference, to be held over BrightTalk, promises a range of workshops and a focus on best practice around Covid-19.
- The **West Midlands Branch**, which cancelled its June conference, is to hold a *Festival of finance* in October, with 14 workshops in a week.

HFMA branches are adapting how they deliver **CPD** to their region. To find out what is happening locally, contact your branch administrator or email **leanne.lovelock@hfma.org.uk**

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

Former HFMA president **Andy Hardy** (pictured) was formally appointed CIPFA president at the institute's annual general meeting in July. Mr Hardy, who has been the chief executive of University Hospitals Coventry and Warwickshire NHS Trust since 2010, previously served as the trust's chief finance officer for six years. He sits on a number of boards, including the West Midlands Academic Health Science Network, and in 2016 he was appointed professor of industry at the University of Warwick. He became HFMA president in December 2013.

University Hospitals of Morecambe Bay NHS Foundation Trust director of finance **Keith Griffiths** is to leave the trust at the end of October to take up a new role in the North West of England. Mr Griffiths has been appointed director of finance and resources at Cheshire and Merseyside Health and Care Partnership.

Rob Forster (pictured) has become chief finance officer and deputy chief executive of Liverpool University Hospitals NHS Foundation Trust – a merger of Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust. Mr Forster was previously director of finance and deputy chief executive at Wrightington, Wigan and Leigh NHS Foundation Trust.

Patrick McGahon has retired from his position as director of finance and information at Tees, Esk and Wear Valleys NHS Foundation Trust. Mr McGahon is a member of the HFMA Policy and Research Committee and chairman of Carlisle College, part of the NCG Group.

Cambridge University Hospitals NHS Foundation Trust chief finance officer **Paul Scott** has been named as chief executive of Essex Partnership University NHS Foundation Trust.

South Eastern Health and Social Care Trust in Northern Ireland has appointed **Wendy Thompson** (pictured) as its director of finance and estates. Ms Thompson previously held the post of assistant director of finance at the Health and Social Care Board.

Di Ormandy has retired from her role as head of the North West Skills Development Network (SDN). Ms Ormandy has spent more than 35 years working in the NHS in the North West, including the past seven at the SDN. Former Future-Focused Finance programme director **David Ellcock** has become the new director of the North West SDN.

Suzanne Robinson has joined the Greater Manchester Mental Health NHS Foundation Trust as director of finance and IM&T. Having served as chair of the HFMA Mental Health Finance Faculty and senior responsible officer for the Future-Focused Finance value maker programme, Ms Robinson was previously executive director of finance and deputy chief executive at Pennine Care NHS Foundation Trust.

Dean to lead at new trust

Black Country Healthcare NHS Foundation Trust has named Georgina Dean (pictured) as chief finance officer.

Ms Dean was NHS England and NHS Improvement's director of operational finance for the Midlands region. Prior to that, she held senior finance roles at Birmingham Women's and Children's NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust.

Black Country Healthcare NHS Foundation Trust, which provides mental health, learning disability and community care, was formed on 1 April, merging the Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust.

Ms Dean said: 'I am really pleased to be joining the trust's board as chief finance officer. I look forward to getting to know the organisation and in particular meeting staff, service users, carers and families.

'I am excited to support this newly merged organisation, and although Covid-19 has brought many challenges, it has also brought many opportunities, which I want to build on while continuing to improve services for our communities.'

Andrew Bone (pictured) has been appointed director of finance at NHS Borders – his first executive director role. He previously served as lead business partner at NHS Lothian, with responsibility for financial planning, forecasting and reporting. He succeeds **Carol Gillie** at NHS Borders following her retirement.

Ian O'Connor has been named director of finance at Dartford and Gravesham NHS Trust. An experienced finance leader, Mr O'Connor has held board-level positions for the past 18 years.

NHS Highland has appointed **David Garden** director of finance. He has worked for NHS Highland for the past 30 years, most recently as head of financial planning and interim finance director.

Essex Partnership University NHS Foundation Trust (EPUT) has named **Trevor Smith** as its new executive chief finance officer and resources officer. Mr Smith will join the trust this autumn from The Princess Alexandra Hospital NHS Trust, where he is currently deputy chief executive and chief finance officer. EPUT's outgoing CFO, **Mark Madden**, is to retire in October after 28 years of working in the NHS.

Brian Baker, head accountant, commissioning (North and West) of Northern Ireland's Health and Social Care Board, is set to retire at the end of this month. Although expected to officially retire at the end of May this year, Mr Baker returned in June to cover the position until a replacement was recruited.

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

"We are committed to devolution and we are working through it, but it needs to become real, delegated authority to people at local level"
Paul Brown, Staffordshire and Stoke-on-Trent clinical commissioning groups

Brown excited by strategic opportunity

On the move

Paul Brown has joined the Staffordshire and Stoke-on-Trent clinical commissioning groups as chief finance officer to help shape commissioning by moving to the system level.

'Moving away from the traditional contractual arrangements between commissioning and providing creates a brilliant opportunity for us to work in a completely different way,' he says. 'Sometimes CCGs have struggled to have real influence in the system. The strategic commissioner idea excites me – creating something strategic that works at a system level but also helps local decision-making.'

Change happens at clinician-to-clinician level, he adds. But that can get lost within the artificial confines of traditional contracting, which can lead to multiple agreements between commissioners and providers. Contracting through an integrated care system (ICS) ensures more sensible decisions are made and the contractual barriers to change are lifted, he says.

The six Staffordshire CCGs are not yet an ICS, but are building together. 'Staffordshire has a history of difficult relationships, but last year – 2019/20 – the system created an intelligent fixed payment system,' Mr Brown explains.

This is similar to the aligned incentives contract used elsewhere in the NHS and has reduced conflict. 'Rather than having to have regular arbitration and argument, we have an agreed position across the system. The system started to work together and has come out with an agreed ICS position.

'People have started to see the benefits of us becoming a merged strategic commissioner and alongside that there is a massive planning role for us in the system for the migration to integrated care providers and primary care networks.'

One of his main objectives is to manage the system finances between the partners under the fixed payment system. He also acknowledges that Staffordshire and Stoke-on-Trent still have significant ongoing financial problems, with a £156m underlying deficit overall.

'The fixed payment system made the first step as it stopped everyone arguing over the deficit or which part of the system should have which bit of the debt. This has enabled relationships to flourish. The second thing, which will be at least as difficult, is fixing the underlying deficit, but we are confident that it can be done.'

Central to that will be the devolvement of decision-making to primary care networks (PCNs) that will be key partners in delivering the improvements on the ground.

'It's all about finding the balance between what needs to work at scale and what is devolved down. We are committed to devolution and we are working through it, but it needs to become real, delegated authority to people at local level.'

But devolution cannot end up with 25 PCNs doing their own thing, reinventing the wheel each time, he says. The CCGs want to tackle unwarranted variation, but he feels sometimes the NHS faces data overload. 'Sometimes you can't see the wood for the trees, but with the PCN population at around 50,000, you have enough to look at variation but it's small enough to get the practices around the table.'

After training as an accountant on the NHS training scheme, Mr Brown spent his first 17 years after university working for the NHS in London, Kent and Sussex. Ten were as finance director in three provider trusts, spanning acute, community and mental health. A further 16 were spent as a management consultant, working in health, but also education, local government, central government, housing and nuclear power.

He returned to the NHS in 2018 as chief finance officer for eight CCGs in North West London, before joining the six Staffordshire and Stoke-on-Trent CCGs in June.

On the challenges of joining a new organisation during the pandemic, with many staff working from home, Mr Brown says: 'It has been strange, but it has worked.

'I started during the lockdown and the CCGs were working 100% remotely. Given that, it has worked incredibly well. We've used Microsoft Teams and I feel I've got to meet everyone in the system. It might be strange when we meet for the first time in person. I've made a few changes to the finance team and all have responded well. I can't think of anything I've done [in lockdown] that I wouldn't have done anyway.'

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- Value and Innovation Award
- Governance Award
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