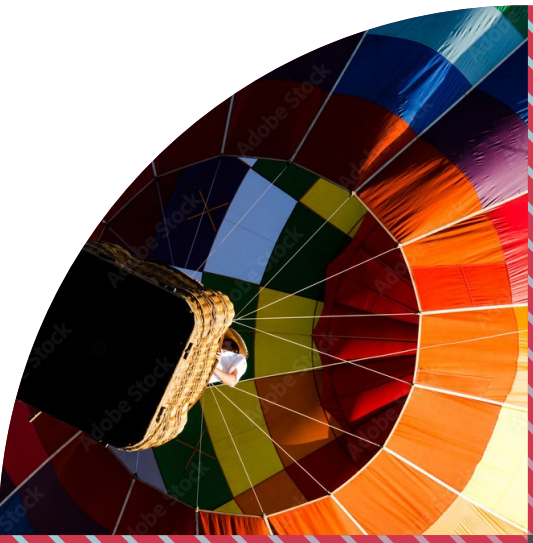
DAC BEACHCROFT

Issue 23
Tackling Inequalities

Health adviser



TACKLING INEQUALITIES

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Foreword

Much of the recent media attention on health and social care in the UK has been focused on backlogs and recruitment challenges. While there is no doubt that the pandemic has left an array of challenges which we continue to grapple with and it is right that focus remains here, we must also keep in mind two things.

First, that there are many positive stories, changes and outcomes that also form part of the pandemic legacy. These stories, written in a time of extreme strain and pressure, tell us a tremendous amount about the principles which our sector is built upon: collaboration, commitment and resilience.

Second, that pre-pandemic priorities must not be swept away, particularly where the past few years have sharpened the need for those issues to be addressed. Previously, we have outlined the need for a focus on 'transformation', not merely 'recovery'. As we continue to emerge from the shadow of Covid-19, the system must not seek to restore itself only to where it was, but to go beyond that.

It is with these points front-of-mind that we focus this edition of Health Adviser on the theme of 'tackling inequalities' in health and social care. The UK health system can – and does – provide world-leading treatment and care, but if that care is not reaching the people it needs to reach, it is failing.

Many of the positive recent strides forward that have been taken, have at their heart the goal of reducing inequality, improving access and improving outcomes. This must continue.

Critical changes have been made, for example, across the public health system in terms of governance and organisational structure. Moves to integration and place-based leadership are centred on better links with communities and we must continue to assess how these are playing out, to ensure their effectiveness.

Part of this monitoring and assessment comes down to data and its role in providing better, broader and safer delivery of care. This includes metrics for population health management, datasets for guiding innovation, and much, much more. Given the very real cybersecurity threat, this must all be done while ensuring confidentiality is protected and data is safe and secure.

Elsewhere in the system, the role of charities must continue to be acknowledged. The collaborative power of public, private and third sector organisations was highlighted during Covid and is clearly a vital element of both tailoring care (looking 'beyond the stethoscope') and creating capacity in response to staffing challenges. Not every health issue should be dealt with in a hospital setting, nor is that what patients want. A preventative, rather than reactive, approach will also help tackle the inequality challenge.

Speaking of challenges, a big change is occurring at a finance and accounting level, as the IFRS16 standard and associated implications for capital budgets is added to the list of new issues for providers to contend with. This edition covers each of these topics, and more.

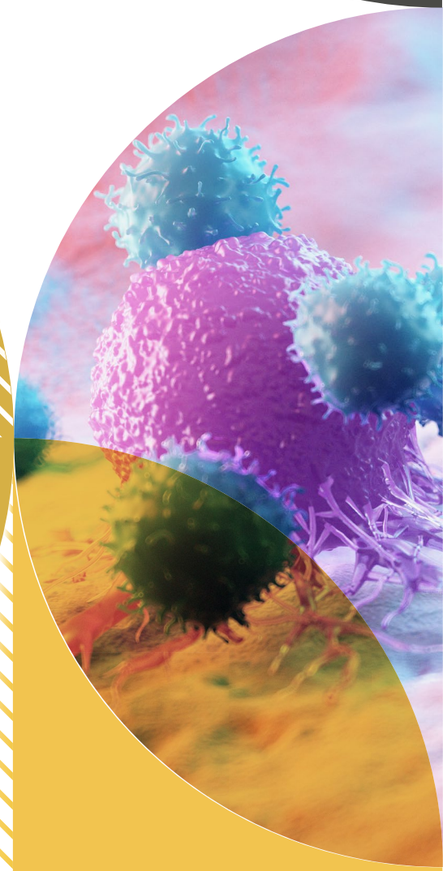
It is clear that 2023 is already proving to be a busy year filled not only with challenge, but with great opportunity. Opportunity to improve the way care is delivered, where and how it is delivered and, crucially, who it is delivered to.

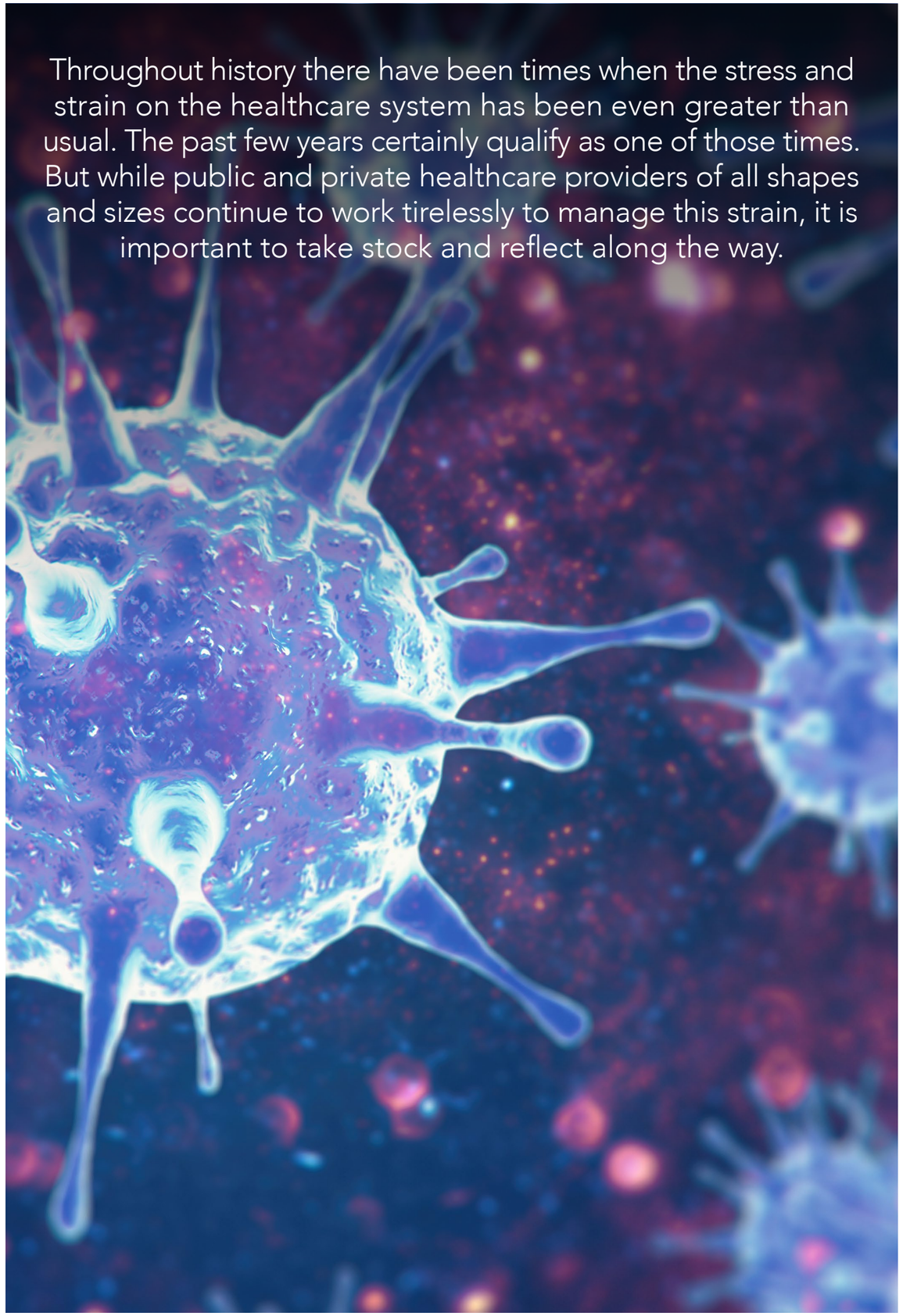
Nigel Montgomery
Head of Health
+44 (0)117 918 2321
nmontgomery
@dacbeachcroft.com

Living with Covid:

Pandemic-proofing our future

There is no doubt that Covid-19 will leave a lasting legacy. But what does that look like and how might we be better prepared for future pandemics? **Charlotte Burnett** explores.





Throughout history there have been times when the stress and strain on the healthcare system has been even greater than usual. The past few years certainly qualify as one of those times. But while public and private healthcare providers of all shapes and sizes continue to work tirelessly to manage this strain, it is important to take stock and reflect along the way.

Some of the key lasting legacies of Covid-19 are sector-agnostic. This includes the transformation it has brought to working patterns, with new service delivery models and new methods for collaboration. The task now is four-fold. To live with Covid, to deal with the care backlog, to be better-prepared for future pandemics, and to continue to reduce healthcare inequalities.

This may sound like an uphill task, and indeed the heroic efforts of recent years will need to be carried forward, but much progress continues to be made. Alongside the determination and talent of the workforce, patient adaptability and developments in technological infrastructure have been crucial in driving the necessary change.

The pandemic led to an unprecedented amount of collaborative working within the healthcare system, particularly at a local level where trust and relationships between partners were strengthened and enhanced.

Much of this continues, some doesn't. This is to be expected, insofar as crisis measures cannot go on indefinitely. The independent sector has waiting lists of its own to contend with, but public-private (and third sector) collaborative success stories must not be forgotten.

As noted, technology has also proven transformative in streamlining communication and providing a primary interface between providers and patients. GPs, for example, have not returned entirely to their pre-pandemic appointment structure, instead further embracing technology as we have seen across the sector. Technological triaging and remote delivery as the first port of call is now often the norm. Healthtech organisations now need to adapt to see what collaboration looks like in this new reality, as the NHS starts doing some things **'in-house'**.

It is unequivocally clear that technology holds the power to facilitate and lubricate pandemic recovery. This will, of course, not happen overnight, but such moments of potential system reset can prove incredibly useful in driving longer-term, positive change.

> **"The pandemic has forced significant changes to the healthcare industry, leaving many feeling as though they have awoken in the recovery room after a major operation. As the dust begins to settle, there will be a need for rehabilitation and re-evaluation of how we approach healthcare in the future. Fortunately, technology is available to help us navigate this new landscape and protect ourselves from future challenges,"**

says Umang Patel, Chief Clinical Information Officer at Microsoft.

Action to tackle waiting times and unlock additional capacity is occurring through the establishment of virtual wards and extra diagnostic centres – 91 are already operating and have delivered more than 2.4 million tests, checks and scans since summer 2021, according to government ministers. These community diagnostics centres (CDCs) are helping to ease the Covid backlog, delivering 11% of all diagnostic activity in September 2022, with the goal of this reaching 40% by 2025.

The centres are typically located in the heart of existing communities, for example in shopping centres or sports stadiums and are therefore well-placed to reach – and meet the needs of – local populations. This reach is key in the effort to tackle inequality up and down the country.

One example is the Barnsley CDC, aimed at improving the productivity and efficiency of diagnostic activity, with statistics already showing that waiting times for imaging diagnostic services such as ultrasounds, x-rays and breast cancer screening have significantly reduced. The Barnsley CDC is strategically located within one of the most deprived areas of the town, close to retail focal points and well-served by both bus and train transport links.

> **"This convenient and accessible location in the heart of Barnsley will not only provide greater local capacity for these vital diagnostic services, but it's hoped more people will feel able to attend their regular check-ups and so help in early detection of disease thereby reducing health inequalities"**

says Bob Kirton, Barnsley Hospital NHS Trust's Deputy Chief Executive and Chief Delivery Officer.

Elsewhere, the government has set up a taskforce to assess how unlocking extra space in private hospitals can contribute to back-log-cutting. If the willingness to engage in collaborative exercises shown by the independent sector during the peak of the pandemic is used as a measure, this should be expected to deliver results, quickly.

Pandemic-proofing

Much has been said and written about the response to Covid-19 around the world. Whether international leaders should have heeded the advice of figures like Bill Gates is largely irrelevant now, but better detection of early warning signs, and improved communications and information-sharing between and among countries should be the norm, going forward.

Domestically, the system must do all it can to minimise the risk of, and mitigate the impact of, future pandemics. It may not be possible to predict black swan events, but investing in system readiness based on past learnings represents prudent preparation. Thorough contingency planning should be in place and, from an employment and recruitment perspective, this must include looking at where and how to draw people into the system to address areas of heightened need.

The volunteer community will play a key role, but leadership figures must plan ahead to ensure those that are willing and able to assist can be mobilised quickly (as we saw in so many places during the pandemic) – and safely.

Former healthcare workers and NHS staff will be one cohort, so contacting those individuals and providing them with means to proactively contact hospitals, will be crucial. The creation and development of ongoing networks of healthcare alumni will be a useful exercise in this regard, so that there is an existing pool of talent to draw from and who can be contracted easily.

Keeping people in the workforce is another challenge, as is attracting new talent. Public sector staff morale understandably took a hit as a result of the extreme pressure endured throughout Covid, with 90% of healthcare leaders concerned about its long-term impact on the wellbeing of their staff.

However, the pandemic has exposed a new generation to the value of the UK's healthcare system and reinvigorated support for the NHS. At its conception, the NHS was a post-War promise to the British people, and the founding principle that healthcare should be free at the point of access has long been a point of international difference and domestic pride. This long-standing reputation is now threatened by staffing and workforce issues which have led to strike action, alongside major infrastructure challenges. Leaders must address these issues head-on.

Across the national health system, the question of central and local once again rears its head, and is a crucial consideration in the context of reducing inequalities. International efforts to develop and roll-out vaccines at pace has been exceptional in terms of getting doses into arms.

But vaccine hesitancy was a very real challenge which was effectively mitigated through very local and targeted provision. National and international vaccine development and rollout, coupled with local delivery and trust-building, ultimately worked very well.

> **"This is the year in which the statutory framework for integrated care systems (ICSs) have to prove themselves. The second and fourth pillars of the ICS statutory objectives will be key – around health inequalities and around making a contribution to the economic recovery and regeneration of the communities in which we serve. The anchoring agenda is where I expect to see really big change, creating opportunities for local people in workforce terms and building skills, particularly for those from the most deprived communities,"**

says Mike Bell, Chair of Lewisham & Greenwich NHS Trust and former Chair of Croydon Health Services and Barking Havering & Redbridge Hospitals Trust during **'peak pandemic'**.

There is widespread acknowledgement and acceptance that central and local must peacefully coexist. National direction and local execution is the recipe for success which we have arrived upon.

> **"You have to have a hybrid approach between national and local,"** says Rupert Dunbar-Rees, CEO of Outcomes Based Healthcare. **"It's not an either/or, otherwise the system grinds to a halt."**

As a specialist in data analysis, Dunbar-Rees sees the importance of the central and local being configured appropriately alongside each other, harnessing the proven benefits of **'big'** and **'small'**.

> **"Central and local need to have good, two-way feedback mechanisms. Granular local level data is great, but ultimately it needs to be comparable out-of-area on a like for like basis, on national scale. Otherwise it's hard to know what good or bad looks like,"**

says Dunbar-Rees.

The vaccine example is a pertinent one because of the sheer scale of the effort required. Without targeted local provision based on local health needs and understanding by commissioners, rollout would have been far less successful. Community support is widely viewed as essential, for example in increasing take-up and overcoming hesitancy by creating pop-up centres in religious destinations to ensure inequalities didn't proliferate because of scepticism or lack of trust and understanding.

'Vaccination to vocation' efforts now seek to capitalise on the role community (and faith) groups played in providing vaccination locations and reaching into the most disadvantaged communities and harnessing that as one solution to the workforce challenge.

> **"It's a major opportunity. The more we demonstrate that the NHS is there for the most deprived communities, the more we can earn trust. The onus is on us to build that trust and systemic changes are needed to shift the dial,"**

says Bell.

The focus on place is a, if not the, major learning from Covid.

> **"Expensive nationally driven programmes tended to deliver frustration, whereas those that galvanised the voluntary sector and community organisations, rooted in place, really delivered. We have the potential to build upon community assets developed during Covid and I hope we learn that lesson in how we shape things in future,"**

says Bell.

Throughout 2023 and beyond, pandemic recovery must therefore be balanced alongside short-term backlog-reduction, long-term pandemic-preparedness and the ongoing battle to improve outcomes and tackle inequalities.

Charlotte Burnett
Partner, Leeds
+44 (0)113 251 4785
ckburnett
@dacbeachcroft.com

Joint appointments:

Charting a path through murky waters

Scarcity of staff across the sector is well-documented. But this applies not just at the point of care. At a leadership level, harnessing the right skills and experience to drive integration and the population health agenda is a key challenge. **Udara Ranasinghe** looks at how deploying talent across multiple organisations can maximise impact and bring greater strategic alignment.

A clear trajectory has been apparent in the governance of healthcare in the UK.

Various reforms have had at their core the goals of increased collaboration, greater synergies and efficiency at a place-based population health level. But with each move to greater integration and collaboration come questions around legal structures, employment considerations and potential conflicts of interest.

Following the shift from clinical commissioning groups (CCGs) to integrated care boards (ICBs), there has been an increasing trend of jointly appointing senior leaders to posts in multiple organisations. In the absence of formal mergers, or other amalgamations of organisations, this route to appoint joint chairs or joint CEOs provides central direction over a local health economy with a footprint larger than any single NHS body in the locality. The overarching rationale here is that these joint-appointees will act in the best interests of the system as a whole, and in many areas this is working well in practice.

One such area is East London, North East London, Essex and Kent. Eileen Taylor, who started in post as Joint Chair across East London NHS Foundation Trust and North East London NHS Foundation Trust on January 1 2023, is focusing on enabling collaboration and innovation.

> **"My hope is to build on the close working already in place with ELFT through the North East London Mental Health, Learning Disability and Autism Collaborative and the North East London Community Health Collaborative,"**

says Taylor.

> **"We can improve access to services, address health inequalities and improve outcomes."**

Taylor hopes that a shared vision for services can be developed that takes account of lessons learned in providing services across Bedfordshire and Luton, Essex and Kent.

The theory

Joint appointment, in theory, allows for the network of Trusts to be better-connected and lends itself to increased information- and expertise-sharing, reducing the natural instinct for competition between different units. It should also foster a more cohesive culture within an ICS and help with the spread of new practices, models and learnings.

From a legal standpoint, a joint appointment involves a situation where a (typically senior leadership) figure is engaged (if their position is as a Non-Executive (e.g. Chair) or employed by two organisations at the same time, in the same or similar roles. It is a much more complex mechanism than, for instance, secondment, where one organisation would remain the legal employer or engager of an individual sent to work elsewhere on a temporary basis.

While many NHS institutions will operate and maintain similar standards and policies, new contractual arrangements are necessary to dictate the specific responsibilities of any joint-appointee. Salary determination and disciplinary issues are further considerations, alongside the chief complicating factor of potential conflict of interest. Key questions surround where duties of good faith lie and how decisions are made if priorities compete or even conflict.

In theory, joint appointments present a tricky balancing exercise for post-holders as they are required to act in the best interests of those they are engaged or employed by. In practice we have seen this legal tension managed through savvy leadership based on transparency and inclusiveness but nevertheless it is a tension that continues to persist – what for example is a joint-appointee to make of a decision in which one organisation they are engaged by loses out at the expense of the other? Should they even participate in making such a decision? What is the appropriate governance around decision-making to ensure all appointing bodies are properly engaged? Options include carving out the responsibilities of a joint-appointee so that decisions where the interests of their appointing organisations may not be aligned are taken by others. This can work up to a point, but where such decisions are a frequent occurrence that may undermine the usefulness of the joint arrangements.

From a regulatory perspective, there are challenges for the Care Quality Commission (CQC) in overseeing assessment of 'well-led' at board level when board representatives are shared and provision is split between different organisations with shared leadership. This is more so when NHS bodies adopt a **"group board"** that oversees the group while there are **"local"** boards that manage each individual Trust in the group. Fit and proper person tests also become more complex and, should something go wrong in one area, how does that impact a leader's roles elsewhere? Despite the challenges, the CQC recognises the need for these arrangements for the benefit of health systems and is supportive of efforts to achieve integration.

"There are many challenges facing the leaders on the ICBs. From our previous work across local systems, we know that better outcomes are possible for people in places where system leaders work well together,"

says the latest CQC State of Care report.

The reality

The current reality seems to be that the model is indeed working well. But this may be in large part down to the goodwill of the various operators within the system – the NHS has a long history of successfully applying that axiom of a will finding a way with pragmatism triumphing over the legal niceties on many an occasion. However, and at risk of mixing metaphors, at some point legal gravity does tend to reassert itself – often in the face of an unexpected eventuality or a controversial decision where the interests of all bodies that are parties to an arrangement are not aligned. Such occasions underline the need for more formal structural certainty to be put in place. In the absence of measures to minimise legal risk, lingering uncertainty around personal accountability is likely to invite scrutiny of senior figures which may make their roles in implementing pragmatism on the ground even harder.

That said, another positive story to tell comes from South London, where Mike Bell was chair of Croydon Health Services NHS Trust for 10 years until the end of 2022 and has served at Lewisham & Greenwich NHS Trust since mid-2022. Even further back, Bell drove governance synergies by bringing Croydon's Trust and CCG closer together from 2017 – an early forerunner of our current ICSs in all but name.

> "As far as we could within the letter of the law, we effectively merged the Trust and the CCG. We did that toe in the water, cautiously. The first joint appointment was a Chief Pharmacist, followed by a Chief Nurse and joint teams. The concern we had was around workload, but the reality is that it drove a huge amount of efficiency, got rid of an awful lot of transactional meetings and allowed us to focus on the really important issues of patient care and joined up pathways between acute, community and primary care,"

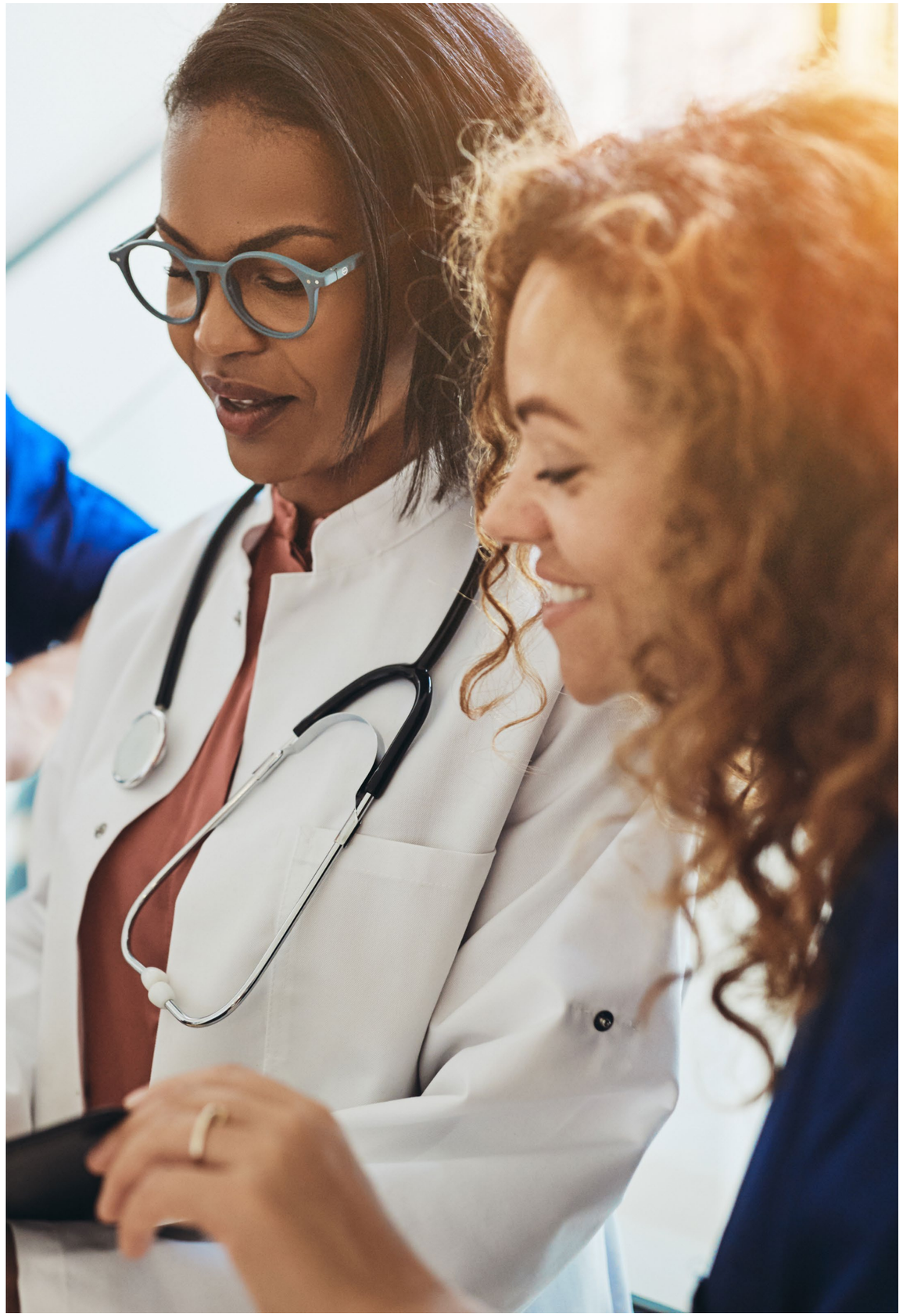
says Bell.

Following early successes, the appointment of the Trust Chief Executive who also held the role of place-based leader followed, along with similar moves for the position of Chief Financial Officer.

> "The Trust typically had a deficit of £20-30 million and the CCG had a deficit of £20-30 million, which sounds like combining things should make £60 million, but by transforming the system and bringing things together we brought ourselves into financial balance. We shared the risks rather than passing them off onto each other. These are very real examples of success in going for joint appointments,"

says Bell, adding that it will be interesting to see things progress within the ICB structure, looking at the role Trust executives might play as place-based leaders across the boroughs they serve.

> "There are real opportunities for progressing that, though I have to say it's easier in Croydon because it's a single Trust serving a single place, which is rare because most Trusts serve multi-borough audiences," he adds. "But there is tangible evidence from the Croydon experience that joint appointments can drive better quality outcomes and greatly enhance efficiency. The learning is there; it's how we apply that in slightly more complex systems."



The route forward

As with any decision-making in healthcare, when a difficult issue arises the stakes are raised and impassioned stakeholders – from executive boards to non-executive members, governors, patients and staff – all (rightly) hold strong opinions and make sure those are heard. Such decisions are never going to avoid scrutiny or challenge and this may conspire to create a recipe for disputes and the threat of judicial review if a Trust or a joint-appointee is potentially acting outside of their powers.

Examine any academic analysis of what constitutes good, effective leadership and you will find that one hallmark is the ability to make decisions with confidence and clarity. Joint appointments could, if not managed proactively and delicately, risk being an inhibiting factor. In the event of contentious decisions being made by those with responsibility for multiple Trusts, the spotlight will naturally be brighter.

To date, where Trusts do have boards in common, they have steered skilfully through, and efforts that give rise to effective functioning ICSs should be lauded. Tackling health inequalities relies on a strong understanding of the needs of local communities. It also requires unbiased, consistent application of service provision across populations and demographics. In this sense, moves to greater integration make sense.

> "Coproduction with our patients, carers and communities is key to the delivery of high-quality care and we must also continue to work with our partners across health and care to identify where we can have the most positive impacts for patients. This will help us to understand how we can improve outcomes and access, as well as addressing inequalities,"

says Taylor.

But pitfalls may lie ahead if underlying governance issues are not addressed. As with any collaboration, goodwill can extend as far as one might like, but if such arrangements fall outside of the scope of a legal framework, certain risks are left exposed.

The tension arises where theory and reality collide.

The fundamental principle is remarkably simple: every organisation must act in its own best interests to deliver healthcare services. These are defined at an organisational rather than a place-based locality level. But the reality is far more complex still, with external factors adding to this. For example Government commitments to pay for additional staff or increased salaries may not come with increased budgets meaning leaders face pressure at a local level to make difficult decisions to square the circle they have been asked to. However the ray of hope here is that responsibility for a larger population footprint will allow joint-appointees and system leaders to tackle these issues in a more holistic way.

> "Through closer collaboration and coproduction we will have a deeper knowledge and understanding of the challenges we are facing across the systems we operate in and this will drive our decision making and priorities going forward,"

says Taylor.

> "I know the NHS is facing further financial challenge and my hope in working in a more collaborative way is that we can look at how we can make best use of the resources available not only to improve patient care but to look at innovative ways we can deliver services and support colleagues to grow, develop and feel valued,"

she adds.

As Taylor and Bell note, these developments are beginning to show strong signs of promise for a better functioning system, with plans for further improvement, enhancement and outcome measurement in throughout 2023. But we cannot ignore the fact that there are untested issues and legal questions to be answered, if joint appointments are to be firmly established as a better option than formal merger. The sector would be wise to seek to address issues simmering beneath the surface, before the governance pan boils over.

Udara Ranasinghe
Partner, London
+44 (0)20 7894 6727
uranasinghe
@dacbeachcroft.com

Better, broader, safer:

How data holds the key to tackling inequalities

The healthcare system in the UK is a complex web, and one which must operate in as seamless and connected a way as possible, if it is to cater to the needs of the entire population. **Darryn Hale** analyses how data is the lynchpin which holds everything together to ensure everybody receives the care they need.

The modern world benefits from – or indeed, relies upon – data in order to function effectively. When it comes to health and social care, the stakes are raised. Data and analytics inform decision-making which really is a matter of life and death.

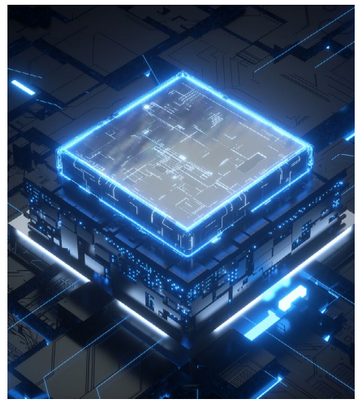
A delicate balance has to be maintained, as data-driven care and information-sharing must be balanced with the clear need for compliance with individuals' rights to privacy and confidentiality.

Get this balance right, and the whole system runs smoothly. At the same time, perfect conditions are created for big steps forward in the efficiency of existing processes, and in the development of new ones. It is at this juncture that real progress will, and arguably must, occur - particularly to ensure inequalities, in both a health and social care context, are understood and tackled.

Better

Of course, data is already being used very well within healthcare. However, as the Care Quality Commission notes, more can be done specifically to use data to reduce inequality.

> "Many of our publications over the last year have highlighted that, in many cases, the current recording of demographic data, for example on ethnicity and disability, is still not good enough."



We stand now at a significant moment in time, with scrutiny thrust upon health and social care by one of the biggest shocks that the system has ever seen. The pandemic forced new ways of working and decision-making, and data lay at the heart of enabling these. This demonstrated the art of the possible in health and social care, but the opportunity to embrace sustained improvements must now be seized and capitalised upon, to secure a better future for healthcare provision and care delivery across all demographics.

> "From very early on in the pandemic we brought together crucial information from across the system – information such as bed occupancy, where we were in terms of ICU utilisation, capacity of A&E departments and the impact of Covid on waiting times. This was pulled together and put into digestible dashboards which were then used to support national decision-making,"

explains Ming Tang, Chief Data and Analytics Officer for NHS England.

> "Data has been crucial to that and it's helped us understand, anticipate, plan and solve problems that services were facing. It helped us track the spread of the virus and make sure we put the right equipment, ventilators and oxygen where it was needed, at the right time, and to prevent hospitals from running out of stock,"

adds Tang.

What worked in crisis mode must be retained and adapted. Sensitivities must be observed and patients must be taken along on the data journey. Even if not attributable to a specific individual, each statistic is tied to a unique story and the potential to improve outcomes. Transparency and openness on collection, storage and use of data is paramount and, handled correctly, can be the most powerful and objective tool in the fight to tackle healthcare inequalities and improve health outcomes.

As technology continues to be transformative for health and social care, data must be used to optimise its use and benefits. The two concepts must be considered together under the banner of 'innovation'. Technology gives rise to new data sets, and data is the guiding force for how new and emerging tech tools should be deployed.

> "Innovation to help tackle the backlog today will continue to help gather data for the future. There is more data being generated than ever before and as we harness this information we learn how to best set services up for the future,"

says Umang Patel, Chief Clinical Information Officer at Microsoft.

An example of this in practice can be found in Northumbria.

> "In Northumbria, AI is being used to assess patients on the musculoskeletal waiting list in order to determine the optimal setting for their treatment. By analysing 220 data points for each patient, the AI is able to minimise the amount of time each operation will take, allowing for more procedures to be completed,"

says Patel.

Broader

Efficiencies aside, digitalising health and social care via tech and data-enabled innovation is also crucial for reducing inequalities. Digital exclusion must be considered, but the point is that services are provided through the channel people want to receive them, to encourage people to interact with the system.

> "It is our obligation to ensure services are equally accessible. We take it very seriously… We are not removing ways of accessing, we are opening an additional channel of accessing care,"

Dr Tim Ferris, Director of Transformation at NHS England told the Parliamentary Health and Social Care Committee in January 2023.

> "While adding a new channel, it also frees up capacity constraints around existing channels, which is important to keep in mind when thinking about digital inequality,"

adds Ferris.

Another benefit of digital channels is that data is processed in real time. This tracking, collection and recording of data means there is no delay in updates or feedback mechanisms. Of course, speed must not come at the expense of accuracy (or security).

In a recent paper, Toby Lewis, David Buck and Lillie Wenzel of The King's Fund explain why collecting accurate data and sharing it routinely and publicly is vital for tackling health inequalities, saying it will

> "stimulate action and allow scrutiny by communities, health and wellbeing boards and regulators alike".

Jackie Gray, Executive Director for Privacy, Transparency, Ethics & Legal at NHS England, has echoed this sentiment around empowering patients by giving them access to their own data.

> "We will not succeed in digital transformation unless we bring the public with us… We are very transparent and transparency is important, but it isn't enough. We also have to engage with the public,"

says Gray.

The pandemic provides a launchpad for capitalising on public sentiment around inequalities. Awareness increased as a result of the spotlight on the national – and local – response to Covid-19 and on the areas and communities which were hardest hit both by the virus' medical implications, as well as by the social restrictions imposed as a result of lockdowns and other preventative measures aimed at stopping its spread.

One upshot is NHS England's Healthcare Inequalities Improvement Dashboard. Its raison d'etre is to bring together disparate tools relating to inequalities in one place. The Dashboard

> "builds on our learning from the Covid-19 pandemic around the importance of good quality data to provide insights to drive improvements in tackling healthcare inequalities".

This move to house key data metrics in one place is sensible, and The King's Fund calls on ICSs and regional public health teams to create a single view of this data that organisations in each local area can rely on.

> "Data must be grounded in accuracy and completeness. The pandemic revealed a legacy of incomplete ethnicity coding being tolerated, while inclusion health groups are currently under-represented in datasets, as the Office for Health Improvement and Disparities has recognised,"

Lewis, Buck and Wenzel add.

The move to building a more long-term, coherent system for healthcare data in the UK was one of the key recommendations of the Goldacre Review, commissioned to inform and sit alongside the NHS Data Strategy. That Review document's title – **"Better, Broader, Safer"** – and its foreword from Professor Ben Goldacre provides an excellent framing of the task and the opportunity at hand.

> "The NHS has some of the most powerful health data in the world. Almost every interaction with the health service leaves a digital trace… This raw information has phenomenal potential… But raw data is not powerful on its own. It must be shaped, checked, and curated into shape. It must be housed and managed securely. It must be analysed. And then it must be communicated and acted upon."

That phenomenal potential was witnessed during the pandemic, when real-time access to data proved pivotal in shaping healthcare leader responses to the rapidly evolving – or mutating – situation. The various uses of data are often clear and obvious: from informing research into treatments, to developing MedTech solutions, to monitoring and improving quality, safety and efficiency of health services.

But interoperability and connectedness is where data truly proves transformative. Systems and platforms must interact, both for the sharing of intelligence and for the avoidance of duplicative efforts. Without this, 70+ years of accumulated data cannot be harnessed effectively.

The most transformative technologies are less effective in the hands of those who do not know what they are dealing with. The same goes for data. The volume of work that has gone into understanding, aggregating, processing and analysing healthcare data in recent years is significant. We know what the goals and challenges are, and we have the tools to address them. The jolt to the system provided by Covid-19 and its ongoing legacy must now be harnessed.

> "Data has been vital in our response to Covid-19 – but it has also proven, without doubt, just how much further and faster we can go in normal times if we continue to use it in this way and we can make sure that we integrate data and reuse data that is already collected from the system and make that more readily available for all,"

says Tang.

Data must be used at all levels. At a hyper-focused, patient journey level, it can deliver better health outcomes for individuals and, at scale, it can ensure healthcare services are meeting the needs of a particular demographic.

Looking further ahead, the importance of being able to use reliable numbers and figures will drastically impact planning and forecasting abilities. If the system is to transform to overcome current pressures, the monitoring, measuring and mapping characteristics of data will be critical.

Safer

Expanding the title of Goldacre's document, we have explored how future improvement lies in better (and faster) use of data and broader coverage of populations. But when it comes to safety, a number of strands must be kept in mind. Safer delivery and outcomes for patients will be data-led, but data security is also a key safety element.

In November 2022, the National Data Guardian wrote to ICBs to remind them of their data protection obligations, in light of concerns that some local record sharing programmes were processing patient information in a manner which may breach confidentiality. The NDG was particularly mindful of the specific legal considerations applicable to 'secondary uses' of data, which is to say using data for purposes broader than an individual's treatment, and noted that organisations **"must also do more to make people aware of how their data are being used and to ensure independent oversight of those uses"**.

But the progress being made around secure data environments – a core recommendation from Goldacre – is to be welcomed and applauded.

> **"The idea is not to share data by giving it to anyone, but to take people to the data. And in a safe, protected environment with the right checks and balances,"**

says Andrew Davies, Digital Health Lead at the Association of British HealthTech Industries, the voice of the HealthTech industry.

> **"NHS data is a huge asset. But only if we can realise the value of it, housing it in the right place, from a safety, accessibility, governance and interoperability perspective,"**

he adds.

Secure data environments are essentially data storage and access platforms. Approved users can access and analyse data without it leaving the secure environment. According to DHSC, organisations will control:

- who can become a user to access the data
- the data that users can access
- what users can do with the data in the environment
- the information users can remove

The data in these environments can be used for planning and population health management, as well as supporting the medical research and development activity of policy analysts, academic and industry researchers.

There are different conditions and policies required for the use of any NHS health and social care data for analysis and research, versus those that will apply to the use of data for direct patient care, with DHSC acknowledging that **"there needs to be fewer barriers in place to make sure that patients receive the care they need"**.

> **"A pragmatic, risk-based approach makes things better. Policymakers understand the value of that data, the concerns around that data, the economic benefit to be gained from utilisation of that data, and the impact on patient outcomes. They're not in the job of making it difficult for industry or researchers or other people to access it. It's about appropriate access and policy is moving in the right direction,"**

says Davies.

Reducing administrative burden is a vital step on the road to improvement. But the NHS naturally, albeit understandably, adopts a fairly risk-averse approach and system-wide simplification to processes for using health data are not easily realised.

> "Patient data issues are viewed as inherently risky. Data governance issues are therefore probably over-engineered, which makes it difficult. For example, if innovators in industry have to go through a different data protection impact assessment every time they go to a different Trust,"

says Davies.

Data protection and confidentiality is a complex area, so treading carefully is understandable. But smarter standardisation of how data is shared, both between NHS and industry and within the NHS and between health and social care, will be game-changing. Associated law and regulation must serve as a safeguard, and an important one at that, but not an impediment to legitimate initiatives designed to improve the quality of care.

Ultimately, better, broader, safer – and smarter – use of data will be a core solution to the inequalities problem. Used properly, data is a practical solution. With the sheer scale of innovation and technological advancement that is happening, data must be the guiding force for how and where such technologies are deployed. If this extends to empowering patients to use their own data, the system can, over time, shift into one that is preventative and anticipatory, rather than reactive.

Darryn Hale
Partner, London
+44 (0)20 7894 6727
dahale
@dacbeachcroft.com

Cybersecurity:

Why systems are only as strong as their weakest link

While Covid-19 has transmitted its way across the globe, it is not only medical viruses that the health and social care system must remain ready to battle. **Hamza Drabu** looks at the importance of preparing for and mitigating the impact of cyber threats.

A cyber-attack occurs every 44 seconds,

according to estimates from antivirus software provider Norton. Organisations of all types, shapes and sizes are at risk. Public and private organisations across the health and social care spectrum are increasingly so, considering the volume, value and sensitivity of information that they hold.

But healthcare is a target not just because of the vast swathes of data it holds. In such a high-stakes environment, employee attention is squarely focused on care provision. A shortage of staff dedicated to cybersecurity, along with a reliance on outdated systems (and little time for training on new ones), conspire to produce a lower level of cyber sophistication compared with other sectors.

Misuse and theft are intrinsically bad, of course. But in the context of tackling healthcare inequalities, specifically, cybersecurity is important for a number of reasons. One is tied to technological adoption and familiarity, and safe, secure data. Remote-first is already upon us. And as healthcare shifts to more anticipatory and preventative models, as well as promoting and empowering self-help, there will be an ever-increasing reliance on digitalisation. An expanding use of digital tools brings with it a heightened need for safety and security in a digital setting.

Another reason is the direct and indirect impact of a cyber-attack. A cyber-attack can lead to loss of service or interruption of business-as-usual operating. This causes backlogs and a widening of existing inequalities. In cases of ransomware, whether victims pay up or not, there is still a financial and reputational cost attached. Attacks breed mistrust and scepticism, too, which may be reinforced depending on the manner in which an organisation responds to an attack. In health and social care, this exacerbates engagement challenges even further.

The NHS has taken strides to improve its cyber resilience and has acknowledged the vital role of data as the best way to identify and understand problems, through the Goldacre Review and Data Strategy. But while healthcare organisations have taken steps to shore up defences, the threat is ever-evolving and increased dependence on technology to deliver better patient outcomes brings new risks, too.

Proper resilience requires ongoing research, technological improvements, training, governance frameworks and, crucially, a culture of risk awareness. Cybersecurity is a critical patient safety issue, not just a fringe IT consideration.

> "Ineffective cybersecurity is a clear and present danger to patient safety in the UK and worldwide,"

notes a paper from Imperial College London and the Institute of Global Health Innovation.

History can also be unhelpful when you consider DeepMind, GPDPR, Cambridge Analytica and Royal Free as examples where policy decisions around data sharing led to issues and have subsequently created caution and nervousness around privacy. External events like Wannacry differ in that the system was a victim of a hostile attack, but compound the trust and nervousness challenge. However, facing up to the reality of past experiences, assessing their impact and taking learnings from them is the only way to improve resilience going forward.

> "We learnt a little bit after WannaCry. The biggest trust in the country had 10-year-old operating systems, which Microsoft had stopped servicing, so it had no updated firewalls. We should be ever vigilant and invest based on such past learnings,"

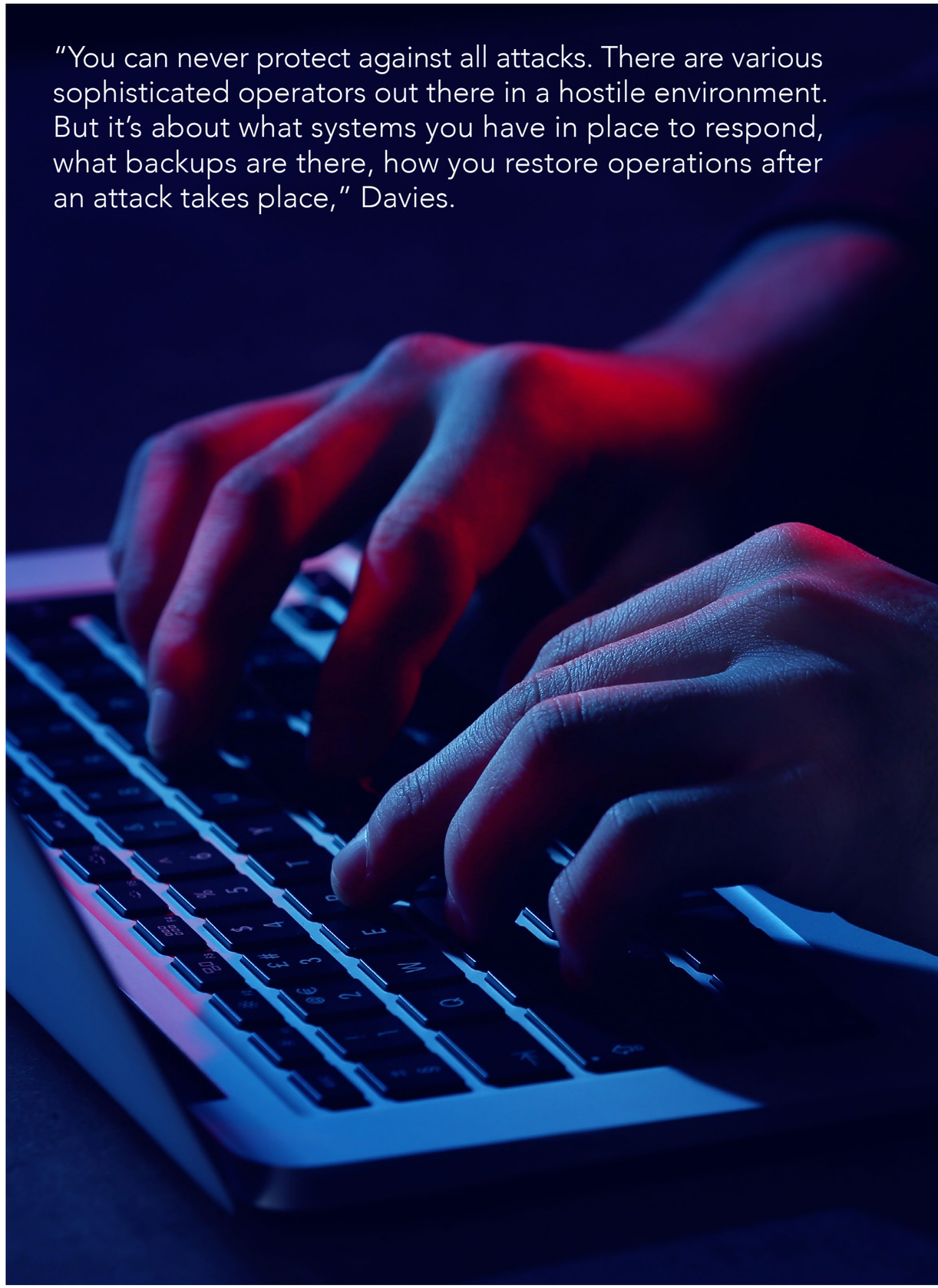
says Mike Bell, chair of Lewisham & Greenwich NHS Trust.

Resource investment should match the seriousness of incident outcomes and acknowledge the likelihood – or inevitability – of them occurring.

When they do occur, the implications of such a cyber incident are far-reaching. Systems can be knocked offline and critical care provision interrupted, patient data can be compromised, stolen or altered, backlogs are created and trust is destroyed. Being better prepared to prevent, react to, and recover from incidents are important in equal measure.

> "When you have systems in place and rely on them, it becomes a patient safety issue when you can't access them – for example if that notification doesn't come through to tell you that a patient needs a particular intervention at a certain time. There can be real frontline impact for patients. It's not just an IT or cybersecurity problem,"

says Andrew Davies, Digital Health Lead at the Association of British HealthTech Industries (ABHI).



Strengthening defences

Investment has also come in the form of strategic partnerships between the NHS, Cynerio and IT Health. Partnering with NHS trusts, the system serves to expand visibility across an NHS organisations' network-connected Internet of Things (IoT), IT and Internet of Medical Things assets and enhance their security in the face of rising attacks. The heightened need for vigilance in 2023 is not in doubt.

> **"We are seeing a surge in demand for our products and services in the wake of recent cyber-attacks on NHS establishments,"**

says Doron Dreyer, VP, International Sales at Cynerio.

Reducing vulnerabilities has been a key learning from the 2017 WannaCry attack and similar cyber events. Part of this is fostering the right approach and cultural response when attacks – or internal lapses – inevitably do happen.

"It's a balancing act knowing where to draw the line in an incident arising out of human error – for example not putting the right security measures in place – versus one arising in spite of the right steps being undertaken. If you are punitive, you run the risk of people hiding problems and not reporting issues. A safe harbour environment is required to encourage discussion, highlight vulnerabilities and address them,"

says Davies.

Stimulating an environment of learning, ensuring accountability but avoiding a culture of blame, is a delicate balance.

Complex governance structures have historically made it difficult to reduce vulnerabilities. But with recent governance changes around Integrated Care Systems, the hope is that central and local-level oversight and administration is simplified and streamlined. This will help cybersecurity receive the attention it deserves from leaders and decision-makers.

> **"Our engagement levels change from trust to trust and we are aiming to get attention on the ICS level, as we see that there is a shift within the NHS to look at cybersecurity from a more holistic perspective,"**

says Dreyer.

Good information governance must also include clear lines of responsibility. As the digital health conversation marches forward, digital security cannot be neglected, and the risk agenda must identify who is responsible for what, and when. This aligns with the three key tenets of cybersecurity: confidentiality (ensuring only those who ought to have access, do so), integrity (ensuring information cannot be modified without detection), and availability (ensuring information can be accessed when needed).

In practical terms, a key concern for NHS organisations is securing their infrastructure and understanding what is running in their environment.

> **"As NHS Digital [now NHSE] is mandating compliance with the DSP Toolkit, trusts are scrambling to get better visibility into their assets, be it traditional IT, as well as IoT, operational technology and medical devices,"**

says Dreyer.

The new solutions mean that trusts have a complete overview of all their assets and ensure compliance with the Data Security and Protection (DSP) Toolkit requirements.

The understanding is there, and security solutions exist. The culture of continuous learning must now spread throughout all areas of the system, to avoid weak spots and inequalities. Central action aside, an organisation as big as the NHS is only as strong as its weakest link.

Late 2022 saw this materialise as an attack on software supplier Advanced sparked widespread outages. Patient referrals, NHS 111, ambulance dispatch, mental health services, urgent treatment centres and other services were all knocked offline.

At the peak of the pandemic, an informal truce was in place, but this grace period now seems to be over as cybercriminals once again have healthcare squarely in their sights. Continued vigilance and, crucially, improvement via investment, is necessary on an ongoing basis.

> **"Clearly there is a long way to go before the NHS achieves the desired levels of cybersecurity, however there is a move in the right direction. More CISO positions are being filled and budgets earmarked for cyber defence are flowing down from NHS Digital [now NHSE],"**

says Dreyer.

Given the UK health and social care sector's reputation on the international stage and the reliance the UK population has upon it, the system cannot afford to undermine its service provision – and in doing so risk widening existing inequalities – by falling short on cybersecurity. That said, the UK is actively showing an awareness of, and desire to defend against, the threats that exist.

"After the US, the UK has the most advanced understanding of the needs to secure health providers,"

says Dreyer.

Becoming best-in-class

Fostering a world-leading innovation – and cybersecure – environment must be the goal – for the nation's reputation on the global stage, and for the health system to transform digitally while defending against threats which widen inequalities and undermine trust and engagement. The solutions are not necessarily simple. But they are out there.

Reducing bureaucracy is one, while greater alignment and interoperability is another. One example of more consistent approaches is in NHS procurement. After receiving regulatory approval for an innovation, the Digital Technology Assessment Criteria (DTAC) checklist targets cybersecurity and risk surrounding implementation, rather than risk attached to the technology itself.

> "On face value the checklist seems reasonable, but trusts are often doing different things. While there is a standard DTAC questionnaire, trusts are adding extra elements. This might be with good reason, but it does make it more protracted – and arguably harder – to get innovation through. It's not always clear what processes you need to go through, across regulatory approval systems, DTAC and NICE [National Institute for Health and Care Excellence]. There are different pathways for often similar types of tech,"

explains Davies.

The country has a vision for becoming an innovation superpower, but there remains much ground to make up on the likes of the US. Alongside easing the bureaucratic burden, creating a more attractive regulatory regime is key to catching international 'competitors'. This is one area ABHI and the UK Government are working together to support the fast-tracking of innovation. Capital investment is also required – this is not just a volume game, but a deployment and incentivisation one. The right funds must be directed to the right places.

> "For the UK to compete, we need faster access to health systems, better investment infrastructure and a friendlier regulatory environment,"

says Davies.

> "It's a cliché but it really is 'digitise or die' and lack of investment is an existential threat. Other countries like France, Germany and Belgium have more structured reimbursement mechanisms to support digital interventions. Ad hoc awards work for the chosen technologies, but the mindset and process must be about fixing the system, not picking a few winners. When innovators chart a path, it should be documented and generalised, otherwise there is a wasted opportunity in terms of broader impact and systems learning and improvement."

Tackling inequalities cannot happen without change and innovation. The UK must make it easier for innovators to stand on the shoulders of giants, while ensuring cybersecurity and defences are improved in parallel, to minimise the impact (and setbacks) which cyber incidents inevitably bring.

Hamza Drabu
Partner, London
+44 (0)20 7894 6411
hdrabu
@dacbeachcroft.com

The role of charities in reducing inequalities

Transformation of health and social care delivery is continually evolving and changing population health needs create demand for innovative and flexible specialist care services. **Anna Hart** and **Emma-Jane Dalley** outline the role of charities in the future of health and social care, including in the delivery of increasingly specialist services.

Community impact

The need to improve access to health and social care services, as part of the levelling up agenda has highlighted the positive impact that locally focussed solutions can have, and many of these local solutions can be, and are already, being driven by charitable providers, working collaboratively with public and independent sector providers.

> **"The learning around the role of communities in responding to the pandemic must not be lost as health equity becomes an overwhelming focus for local partnerships,"**

notes a recent paper from The King's Fund think-tank.

Charitable providers play a key role in keeping people based in the community and this fits neatly with the wider system desire to provide person-centred care that is more cost-effective and improves outcomes for all.

United Response is one such provider, offering support to people with learning disabilities, autism and mental health needs both in their own home and in the community.

"Our work is about people being able to lead a life of hope and purpose, as part of a community in which they experience friendship and loving relationships. The golden thread running through our work has been an unwavering focus on person-centred support. We try hard to never do things 'to' or 'for' the people we support, but with them. Our support is woven into the life of community, making full use of local facilities and community skills so the people we work with contribute to the life of their communities,"

says Tim Cooper, CEO.

Like all areas of the health and care ecosystem, charities are evolving the way they operate and diversifying how they deliver care and support.

For United Response, this includes moving away from the traditional day services model to support people's wellbeing, skills development and relationship-building.

United Response acknowledges the value of care provision in its widest possible sense. This is as much about uplifting and empowering communities as it is about treating medical issues. Tackling societal issues at a community level has dramatic positive implications for health and wellbeing. For United Response, this ranges from donating produce grown in its Green Task Force projects to local community groups and food banks to help address food poverty.

Other examples can be seen up and down the country. At its farm in Cornwall, 5,000 trees have been planted by United Response workers and local community members, which will offset 833 tonnes of CO2. Elsewhere, it runs projects to turn derelict land into a thriving and biodiverse green space for the community.

Such initiatives show the wide scope of impact that charities can – and do – have for population health.

Creating capacity

When it comes to reducing inequalities,

a lot of talk centres on investment and creating new models. But we must also appreciate what we already have – as the examples touched on show – and seek to maximise its impact, rather than overlook or take for granted existing strengths.

> **"Anchors should build on the strength of their communities before looking to new statutory services,"**

argue senior fellows at The King's Fund.

"Integrated care systems have renewed responsibility to pay attention to the voluntary sector's contribution and resilience, and … to prioritise economic and social value. This brings health into line with local government's traditional role in community wealth building. This alignment of responsibility has to be maximised if local community efforts are to thrive."

As backlogs mount and demand for services grow, the role that charities and voluntary groups play in supporting the physical and mental health needs of individuals is increasingly clear and valuable.

> **"VCSE plays a vital role in support for people at home and in other non-hospital, community settings. We need a long-term shift, because we can't afford to be this unhealthy, as a country. The pressures on the NHS are unsustainable – and avoidable,"**

says William Higham, Community Mental Health Director at Rethink Mental Illness.

> **"Look at the Marmot Review on inequalities – the poorest areas have had the biggest cuts. We need investment. We can't run everything through A&E alone. We need to unlock the massive workforce that can be tapped into and meet the challenge of getting people the help they need, when and where they need it,"**

he adds.

Charities are crucial in supporting and creating capacity in the broader health and social care system.

Scaling up impact

A systemic approach must involve the scaling up of impact. Smaller charities involved in commissioning and procurement, for example, undoubtedly provide good services, but struggle to get commissioned for reasons connected to their size and ability to service large contract commitments. Partnership arrangements are one route forward, where joint working brings the scale required for greater impact that would not have been possible for individual entities alone.

The **Durham Mental Wellbeing Alliance Project** is one example of how successful contractual arrangements can be when public, private and third sector organisations are brought together. Home Group, housing, care and support provider, was part of an alliance agreement, agreed in April 2022 with Durham County Council (along with six other charity providers of mental health services) to collaborate in the delivery of preventative and early intervention support services for people with lower-level mental health needs.

> **"The purpose of the Alliance is to deliver integrated, high quality, cost-effective and sustainable care to service users in County Durham within a limited financial envelope,"**

says a Home Group spokesperson.

> **"The Alliance contract and the provider collaboration agreement that sits behind it, sets out the basis on which the provider parties will deliver services within a robust governance framework and with a financial mechanism that rewards effort through incentives and risk/gain principles,"**

they add.

Entering into such arrangements does come with risk and regulatory considerations for all involved but with the Durham Alliance up and running, tangible results are already being seen and felt.

Nearly 1,000 customers across the county are benefitting from the Alliance's support, with significant improvements in wellbeing and quality of life being recorded. A vast majority (96%) have received a positive experience and 93% would recommend it to family and friends.

Another example of a voluntary sector alliance is Rethink's project **'Somerset Open Mental Health'**, based on the concept of co-production, actively listening to the community and providing a safe space to share experiences in a non-clinical setting.

> **"Early feedback and metrics indicate that this has contributed to a 10% reduction in A&E load in the local area,"**

says Higham.

> **"Money is always tight, but enormous savings can be unlocked. The earlier you get to people, the less intrusive the action needs to be, and focus on prevention rather than cure – or earlier treatment in a community setting – means there is less chance a mental health crisis will impact other parts of someone's life,"**

he adds.

> **"Partnerships that deliver within an established framework, done right, are an extra limb for the statutory sector and put resource directly into the community. Organisation and culture are important, so we have to avoid shotgun marriages and drive forward properly structured alliances. We also need an open-minded approach to regulation to enable and support such moves,"**

says Higham.

A safe and regulated environment

This formalisation and governance of the role of the charitable and voluntary sector must continue to be developed, regulated and measured.

Measurement of impact can be tricky, and has the potential to distract from "getting the job done" by diverting resources. But it is possible. The Charity Commission has long lobbied for charities to provide more evidence of the impact they are making, both through service provision and on campaigning issues. The voice of the voluntary sector must not go unheard.

Alongside metrics, regulation and safety is a vital area of continuous development. The spirit, power and impact of those who care cannot be underestimated and this positive energy, will and passion must be harnessed to improve outcomes.

> "The priority is on providing the quality care we all hope we'll get if we're ever in the situation of needing it. Staff and volunteers give up time to be trained, build up knowledge and experience on top of the time commitment they dedicate to care-giving itself. Even non-voluntary organisations wouldn't function without volunteers and their spirit of caring from the heart. The passion and commitment is phenomenal,"

says Brett Edwards, Health & Safety Director at RMBI which provides care to the masonic community, their families and beyond.

> **"During Covid, for instance, even when nobody truly understood the impact of this scary virus, people were going into environments with an increased health risk and into environments which took a media battering, in terms of the reporting around the risks of being in a care home at that time,"**

he adds.

But that spirit alone is not enough. Charitable and voluntary organisations must operate effectively but also safely. This is not always straightforward. Edwards previously worked in the corporate world where compliance, health and safety is much more rigid and, in that regard, easier to manage and follow.

> **"When you come into a place where people live, you simply can't implement the same regime in someone's home as you could in a corporate setting. Residents have their own experiences, customs and risk tolerance so you have to cater for the individuality of people who have different medical conditions and capacity issues,"**

he says.

Appreciating the nuances of dealing with issues like dementia, which manifests in many ways, not always consistently, is one challenge, while another is to protect and preserve the health and safety of those working in care, particularly in a frontline, operational capacity.

> "These people all care about other people. Obviously that is to be lauded, but there can be a tendency to forget about or neglect caring for themselves, like the police officer running towards, not away from, a knife attack,"

says Edwards.

The silver bullet lies in creating regulation which supports and enables, focusing on highlighting the benefits of positive action, rather than invoking fear around negative reinforcement.

> **"Regulation should empower people who care to make decisions and create safe environments. It's not about the consequences of getting things wrong, but the benefits of doing things right. Legislation should reinforce the right course of action, morally,"**

says Edwards.

Beyond the stethoscope

Looking at where health and social care is now, there is a clear need to get people out of hospitals and back into the community. Longer term, to tackle the resource challenge and the inequalities challenge, the vision must be to improve public health and thereby prevent crises and pressure points.

> "We need to create a healthier society. We can't afford to perpetuate a mindset where the stethoscope is the only tool,"

says Higham.

On both fronts, charities and voluntary groups will continue to perform crucial functions.

> "We won't achieve truly integrated health and care without the voluntary sector – it's that simple,"

summarises Lord Victor Adebowale, Chair of the NHS Confederation.

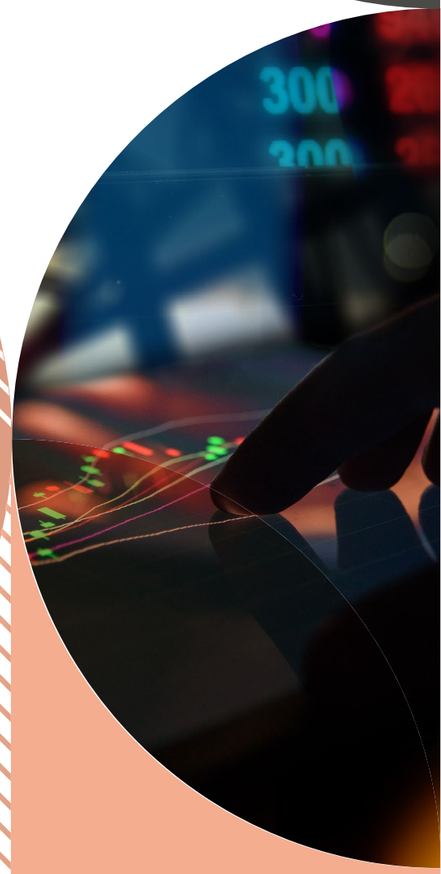
Anna Hart
Partner, Newcastle
+44 (0)191 404 4177
ahart
@dacbeachcroft.com

Emma-Jane Dalley
Partner, Bristol
+44 (0)117 366 2960
ejdalley
@dacbeachcroft.com

Healthcare infrastructure:

Is private investment the elephant in the room?

The NHS estate is vast and has always been complex to manage. Now, accounting changes, constrained national budgets and expiring leases provide an array of challenges. **Stan Campbell** assesses where we stand, five years on from the Naylor Review.



NHS data shows that the total cost of running the NHS estate was £11.1 billion in 2021/22. Clearly, this is not an insignificant sum and is likely to increase further without much-needed investment.

A key recommendation of the Naylor Review was that to satisfy the need for additional investment into NHS estates, a third of funding should come from government money, a third from disposals and a third from private investment. Given the strain on public finances caused by a weakened economy and the cost-of-living and energy crises contributing to calls for health and social care professionals to be paid more, the reliance on disposals and private investment becomes even more critical.

On the disposals side, certain shifts to remote-first entry into healthcare systems offer scope for reducing square footage if the right buyers can be found, and a 2022 NHS Digital report notes that 508 plots of land totalling 623.85 hectares have been declared as surplus by NHS providers. The government response to Naylor confirmed that NHS providers are able to retain receipts generated from the sale of surplus land and property (but these must be used in the same financial year), so income from such disposals could be reinvested locally to help deliver the Build Back Better Health & Social Care plan and tackle inequalities.

However, there are exceptions. Where estates form part of the former primary care trust estates – 50% of the proceeds of any disposal by NHSPS as the Department's nominee would be reinvested in an NHSPS site in the ICS, while the rest could be pooled nationally.

The private investment picture is less clear. It is also politically sensitive, considering the lofty position the NHS rightfully holds in the hearts and minds of the British public. Much investment was previously secured via private finance initiative (PFI), first introduced in the 1990s. Under the PFI funding model, private capital investment funded construction costs for new hospital buildings and paid for their ongoing development and operation in return for regular payments over time.

Some of these contracts will not expire until 2050, and according to UK government and HM Treasury data, payments under operational PFI contracts in the health sector will cost more than £2 billion, or around 2% of the NHS budget. This figure is set to rise, peaking at around £2.5 billion in 2030. While the upfront capital from private sources allowed infrastructure to be developed, the contractual burdens associated with PFI led to significant criticism and the ultimate withdrawal of PFI as a funding option.

Then-Chancellor Philip Hammond launched a government review of infrastructure finance after abolishing the use of PFI, but a hole has been left in its place, and the UK lags the OECD average in capital spend on healthcare. Government pledges to build new hospitals will likely not be achieved if this remains unaddressed.

As an indirect replacement for PFI, the Local Improvement Finance Trust (LIFT) programme sought to increase investment from the NHS and the private sector in the primary care and community estate across the country. With an eye on reducing inequalities, LIFT – which operates with Public Private Partnership (PPP) companies – was designed to make services more accessible for those in most need, with a majority of projects in areas of higher than average health needs.

One attempt to raise private capital for infrastructure projects was the Regional Health Infrastructure Companies (RHIC) scheme (conceived by Community Health Partnerships as "Project Phoenix") which aimed to fundraise in a similar manner to LIFTs, but for larger projects (though smaller than those previously agreed using PFI). The scheme was scrapped before it took off, but a primary benefit was its intention to account for costs on an off-balance sheet basis, meaning projects would not be included in the NHS' capital spending limits.

Accounting for change

ICSs face a range of challenges when it comes to maintaining and upgrading healthcare infrastructure, in light of the Build Back Better Health & Social Care Bill and scrutiny of the New Hospitals Programme. That aside, recent accounting changes are another factor creating challenges.

The IFRS16 accounting standard came into force for NHS bodies on April 1 2022. The effect is that what were historically revenue leases – which did not impact the Capital Departmental Expenditure Limits (CDEL) budget – now go onto the balance sheet as capital. In practical terms, this means that signing up to a 10-year lease, for example, with £100,000 annual rent payment, would now account for £1 million of a Trust's charge against its CDEL. While the CDEL limits have been adjusted upwards for leases pre-existing April 1 2022, what was previously treated as a revenue lease will now consume a chunk of CDEL for new leases going forward.

> **"It is definitely more difficult for estates projects not to count towards CDEL. There may be examples which are off balance sheet where a private provider delivers a managed service by selecting and developing a site and allocating some, but not all, capacity for a Trust to use. In this situation, the Trust payment is for the service and not specifically for use of the building. However, where the NHS is the primary user, it is likely that the asset will represent a balance sheet cost going forward, which means the NHS has to pay public dividend capital and depreciation on the asset, as well as paying the private sector for the services,"**

says Rhiannon Williams, Director, Public Services Advisory at Grant Thornton.

IFRS16 in broad terms covers everything from the leasing of a photocopying machine through to the leasing of entire buildings, so it really is all-encompassing.

The recent introduction of CDEL for NHS Foundation Trusts in addition to non-Foundation Trusts acts as a limit on capital expenditure. A review of all leases in situ as at April 1 2022 took place to inform a one-off increase of CDELs for Foundation Trusts as a result of IFRS16 to ensure its introduction did not result in significantly reduced capital investment plans.

> **"CDEL is already inadequate and the level of investment needed including on the digital front is far higher today than 20 years ago. With IFRS16, things are now getting even more difficult. The IFRS 16 framework is here to stay, with the initial transition year coming to an end on April 1. The hope is that someone somewhere is thinking about this because we have a burning platform when it comes to capital in the NHS. It's looking like this may fall into the 'too difficult' pile,"**

says Williams.

The lived experience matches this summary.

> "CDEL is challenging – like all limits the level of challenge depends on where the limit is set. It's relatively new for FTs, while the calculation for it means there is a mismatch in timing between the technical application of the accounting standard versus the cash transactions as per the lease. For example, at the point a lease comes into force, the annual lease payment is multiplied by term length to arrive at the IFRS16 value that scores against the Trust's CDEL as capital expenditure. With long building leases, of say 40 years, these numbers can be very significant indeed, but in reality the cash impact in year one will only be the annual lease payment,"

says Jeremy Spearing, Director of Operational Finance at University Hospitals Bristol and Weston NHS Foundation Trust.

To exemplify Spearing's point, take the earlier example of a 10-year building lease at £100,000 per year. The accounting standard recognises this as a £1 million charge against CDEL and £1 million is being paid to a landlord, whereas in cash terms it is a £100,000 transaction, per annum, over 10 years. The argument is that the IFRS16 calculation should therefore constitute a non-cash transaction, yet at present it counts in full towards the CDEL, restricting the actual cash Trusts can invest in buildings and equipment. And, of course, the consequence of IFRS16 may be much bigger when you consider higher rents and longer leases.

There is no doubt this has been a headache for NHS organisations, who have had to grapple with a new CDEL framework, the arrival of IFRS16 and ICS changes – whereby CDEL is calculated at individual provider Trust level, largely based on historic depreciation levels, but managed and consolidated across the system.

> "This has shifted how investment decisions are made and prioritised from an individual provider perspective to a system point of view. All three changes taken together have potentially removed significant autonomy for Foundation Trusts and potentially means capital investment decision-making becomes more challenging,"

says Spearing.

These recent changes have left trusts searching for alternative solutions to find capital funding sources not constrained by the CDEL. Potential solutions include land or building disposals and charitable sources. Previous routes such as an income strip where a trust could build the infrastructure it needs, then sell a lease back via a fund, and thereby turn it into a revenue lease, have been ruled out by the IFRS16 accounting change and the ban on future PFI arrangements.

Of course, CDEL is in place for good reason, and public spending cannot go uncapped, but in a post-PFI landscape where new LIFT schemes are in short supply, there appears to be no magic fix for this infrastructure funding challenge.

> "The issue of capital is on the radar but there are many competing priorities for ministers and Treasury to contend with. The NHP has a lot of political backing, but the full funding requirement is not yet allocated and the schemes selected for the programme won't scratch the surface in terms of the full range of hospitals that need investment. Factor in RAAC plank issues where some hospitals are becoming more and more structurally unstable over time and it is clear that some priorities are more urgent than others. It's a case of there simply not being enough money to go around,"

says Williams.

All eyes are therefore on the Secretary of State for Health and HM Treasury, as to how the NHS estate challenge can be solved. The New Hospitals Programme aside, the key question is how will estates be funded going forward? Will there be a replacement for PFI? Will an alternative avenue for private investment be created? Will investment be purely taxpayer-funded?

At present, the problem is that there is no obvious solution to the lack of capital. IFRS16 has made capital challenges even more difficult and it is not clear how hospitals, NHS facilities and assets will be funded.

The hope is that wise heads prevail. Announcements around the increased use of virtual wards to treat up to 50,000 patients a month and free up capacity in physical locations are welcome, but will not solve the infrastructure funding challenge, Longer term, there is hope that the NHS may be exempt from the new accounting changes.

> "It may be decided that the accounting standard's application to the NHS results in unintended consequences or creates perverse incentives. However, if there is no derogation for the NHS on the application of IFRS16, CDEL uplifts would need to take place for leasing to remain a viable route to accessing new infrastructure. There is recognition that this is a big issue,"

says Spearing.

Given the challenges created by the lingering effects of Covid-19 and well-documented strain on the system, NHS bodies and their finance teams would welcome a simplified route forward when it comes to infrastructure funding.

Stan Campbell
Partner, Bristol
+44 (0)117 918 2179
scampbell
@dacbeachcroft.com

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DAC Beachcroft has over 75 years' experience in delivering innovative and practical support across the full breadth of legal services.

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Nigel Montgomery
Head of Health, Bristol
+44 (0)117 918 2321 | nmontgomery@dacbeachcroft.com

Nigel has 25 years experience of handling clinical negligence claims across all areas including cerebral palsy, oncology, paediatrics and plastic surgery. Advisory work includes strategic analysis and implementation of Trust policies, procedures and training in relation to clinical and health and safety risk.

Charlotte Burnett
Partner, Leeds
+44 (0)113 251 4785 | ckburnett@dacbeachcroft.com

Charlotte Burnett advises health sector organisations on a wide range of commercial and contracting issues. She specialises in integration within the NHS and between the NHS and independent providers. She is an expert in primary care.

Udara Ranasinghe
Partner, London
+44 (0)20 7894 6727 | uranasinghe@dacbeachcroft.com

Udara is an employment specialist, having joined the team upon qualification in 1999. He is recognised as a market leading employment lawyer and has a broad skills base covering contentious and non-contentious matters.

Darryn Hale
Partner, London
+44 (0)20 7894 6727 | dahale@dacbeachcroft.com

Darryn specialises in information law in the health sector, including data protection, confidentiality and freedom of information.

Hamza Drabu
Partner, London
+44 (0)20 7894 6411 | hdrabu@dacbeachcroft.com

Hamza specialises in commercial law, regulatory and governance matters. Hamza has advised on a number of projects with an international focus, including advising clients on inward investment projects into the UK, as well as leading on multi-jurisdictional projects alongside an international team of lawyers.

Anna Hart
Partner, Newcastle
+44 (0)191 404 4177 | ahart@dacbeachcroft.com

Anna Hart is a partner in our Healthcare Regulatory Team. Anna specialises in advising clients on a broad range of civil and criminal regulatory issues.

Emma-Jane Dalley
Partner, Bristol
+44 (0)117 366 2960 | ejdalley@dacbeachcroft.com

Emma-Jane specialises in all aspects of charity law and governance and has been advising charities and other not for profit organisations for over 15 years.

Stan Campbell
Partner, Bristol
+44 (0)117 918 2179 | scampbell@dacbeachcroft.com

Stan Campbell is a real estate lawyer in our Bristol office. He specialises in commercial property investment and development with a particular focus on the health and public sectors.

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