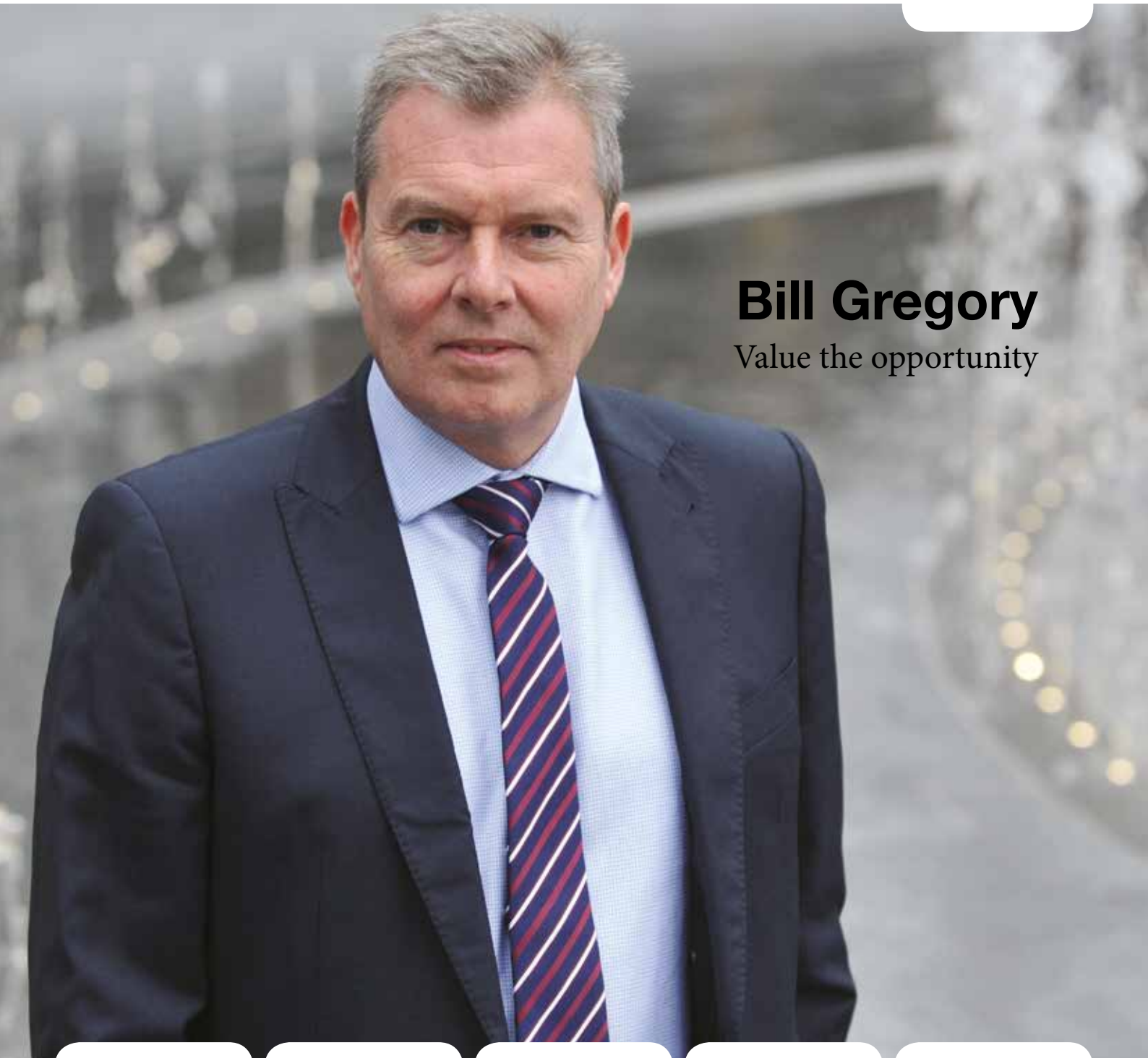
healthcare finance

February 2019 | Healthcare Financial Management Association

www.hfma.org.uk



Bill Gregory

Value the opportunity

Helping you to generate revenue from overseas business

With our team of global advisors and networks, Healthcare UK supports NHS Trusts and private organisations to identify international opportunities, work through potential challenges and support you to generate revenue overseas.

Please get in touch to discover more: **healthcare.uk@trade.gov.uk**

HealthcareUK

A joint initiative between

Department of Health & Social Care | Department for International Trade | NHS England

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

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

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

Professional lives
Yuliya Kosharevska
0117 938 8440
yuliya.kosharevska@hfma.org.uk

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

Subscriptions and membership
James Fenwick
0117 938 8992
james.fenwick@hfma.org.uk

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
BCQ Group

HFMA
1 Temple Way,
Bristol BS2 0BU

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

Alison Myles
Education director
alison.myles@hfma.org.uk

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

ISSN 1472-3379

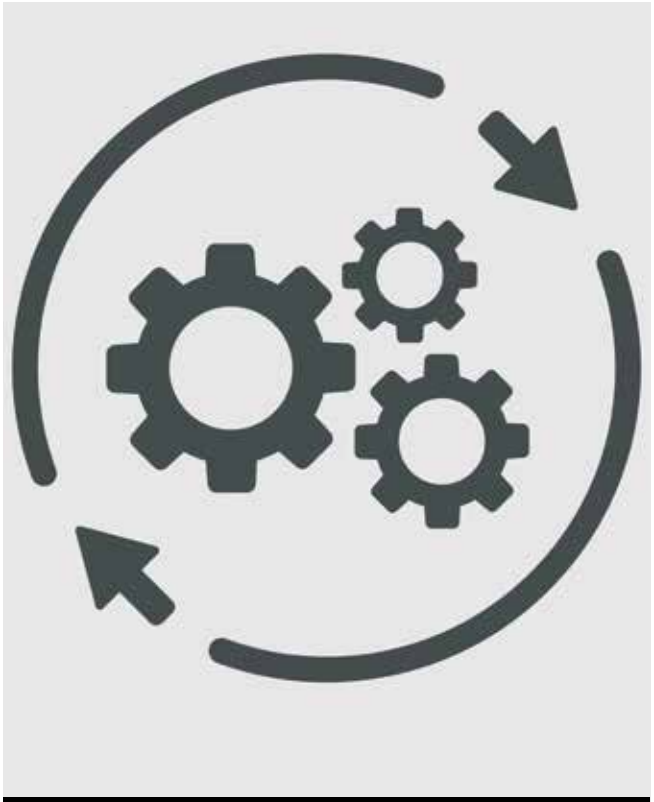
Contents

February 2019

News

Comment

Professional lives



Page 20 **System reset: the new long-term plan's vision for joined-up services and integrated care**

Features

RMS
RADIOLOGY MANAGEMENT SOLUTIONS
SCANNING PEOPLE™

RMS LOVE TO HELP RADIOLOGY DEPARTMENTS MAKE BIG CIP SAVINGS

At RMS we're driven by a passion to help NHS radiology departments make significant CIP savings, reduce waiting lists, *including 2 week waits and complex examinations*, achieve throughput targets, and avoid quota penalties – by maximising in-house assets whilst improving patient experiences.

What's more, our outsourced capacity management solution can be accessed immediately via single supplier framework agreements with The Countess of Chester and Betsi Cadwaladr.

We'd love to help improve your radiology department's CIP savings. To find out how, call Mike Lancaster today on 0161 410 0169 or email mlancaster@rms-scanning.co.uk

---

/ WAITING LISTS REDUCED / STAFF SHORTAGES RESOLVED
/ THROUGHPUT TARGETS ACHIEVED / WINTER PRESSURES EASED
/ QUOTA PENALTIES AVOIDED / IN-HOUSE ASSETS MAXIMISED
/ PATIENT SATISFACTION IMPROVED / CIP SAVINGS MADE

rms-scanning.co.uk

News

NHS welcomes long-term plan but raises delivery questions

By Seamus Ward

The *NHS long-term plan* for England has been welcomed as a wide-ranging programme to refocus the health service in terms of finances and services, but MPs have been told it may not be delivered in full without more money and staff.

The long-term plan, issued in January, outlines an ambitious programme, including moving more care out of hospital and into the community; greater prevention of ill-health; better outcomes and earlier diagnosis and treatment of major diseases; and using technology to deliver innovative care.

It also seeks to ensure that all NHS organisations in England return to financial balance by 2023/24 at the latest.

There is an emphasis on collaboration and integration – integrated care systems (ICSs) that bring together providers and commissioners will cover the whole of England by April 2021. They are expected to drive the plan forward, with commissioners and providers working together on service and financial planning.

NHS England chief executive Simon Stevens promised funding for primary and community services would grow faster than the overall NHS budget. This will create a ring-fenced fund worth £4.5bn a year in real terms by 2023/24 to support this new service model.

The focus on financial balance has a number of aspects, including a new financial recovery fund (worth £1bn in 2019/20); boosting tariff prices, particularly by transferring £1bn from the provider sustainability fund into non-elective prices; further efficiencies; and an accelerated turnaround process for the 30 trusts with the worst financial positions. The number of trusts in deficit is expected to fall by at least 50% in 2019/20.

However, NHS Providers chief executive Chris Hopson told a hearing of the Commons Health and Social Care Committee that he was unsure whether the service could deliver high-quality care within the financial settlement and in the face of increasing demand.

"Everything in the plan is not going to be delivered. There is too much to do for the money and workforce available"
Chris Hopson, NHS Providers

'There are a lot of very good things in the plan, but does it answer the question of whether we can deliver the right quality of care for the money that is available?' he asked.

'I can make a relatively confident prediction here today that everything in the plan is not going to be delivered. There is simply too much to do for the money and the workforce we have available.'

He added that, at least initially, much of the growth funding would have to go into the acute sector to tackle deficits rather than community and primary care. 'How that balance changes over time will be key, and part of it will be how fast we can recover the acute sector deficits.'

Jennifer Dixon: concerns about impact on community and mental health funding

Witnesses also told MPs they were concerned that the plan did not include enough information about capital funding and plugging gaps in the workforce.

Health Foundation chief executive Jennifer Dixon said that the funding settlement broadly matched calculations of the amount the NHS would need to get back into balance, cope with the ageing population and meet NHS Constitution targets. But there was not much room for manoeuvre, and she was concerned the additional funding for primary and community care could be raided to stabilise the financial position in other sectors.

'One of the big priorities signalled is to shift money into primary, community and mental health, which has to be a good thing. But you can only worry that that would be at stake, and first off the line, if the productivity could not be made and demand could not be quelled.'

• *See System reset, page 20*

Gregory takes the reins

Bill Gregory is the new HFMA president, taking over from Alex Gild at the annual conference in December.

Mr Gregory, chief financial officer and deputy chief executive at Lancashire Care NHS Foundation Trust, received the chains of office from Mr Gild before unveiling his theme for the year ahead – *Value the opportunity*.

At the conference, the association honoured 41 students who have completed its *Advanced higher diploma in healthcare business and finance*, the *Advanced diploma in healthcare business and finance* or the *Certificate in making finance work in the NHS*.

Sonita Osborne, head of financial services at George Eliot NHS Trust, was the winner of the Tony Whitfield Award for student of the year. The award was accepted on the night by her finance director Haq Khan, who passed it on to her back at the trust (inset picture).

• *See A clear focus on opportunity, page 16*

CCG allocations proposed to address health inequalities

By Seamus Ward

No clinical commissioning group will be more than 5% under their target allocation in 2019/20, NHS England has said.

Announcing the draft allocations for 2019/20 to 2023/24, the national commissioning body said every CCG will receive a cash increase of at least 17% over the five years. The draft allocations are to be put to the NHS England board on 31 January for approval.

With the formal tariff consultation launched during January (*see page 7*), overall CCG programme cash growth is 5.7% in 2019/20. Without the increase in urgent and emergency prices and funding for the pay deal, overall CCG programme growth would have been 3.4%. Overall, core funding uplifts range from 3.6% to 15.25%.

NHS England chief executive Simon Stevens (pictured) said the funding would support delivery of the *NHS long-term plan*.

The CCG target allocations are based on a revised funding formula that aims to tackle health inequalities.

Two of the areas with the worst rates of premature deaths, Bradford City and Blackpool CCGs, will receive the biggest percentage cash increases in their core services funding of 15.25% and 11.58%, respectively in 2019/20. Total allocations will leave Bradford 3.9% and Blackpool 4.99% under target. Twelve CCGs are more than 5% over target.

Mr Stevens said around £1bn a year would be distributed according to need. 'Tackling health inequalities in our society is not just about fairness but is a matter of hard-headed economics which will not only save lives but also save taxpayers' money and NHS staff time,' he added.

The two CCGs with the least growth are West London (3.6%) and Central London (Westminster) (4.65%).

An evidence review by the Nuffield Trust for the National Centre for Rural Health and Care said the allocations formula disadvantaged rural areas. Although it said the formula attempts to adjust for the higher levels of need in rural area, the trust argued these adjustments are hugely outweighed by factors that tend to move funding to urban areas – market forces and health inequalities.

The net effect was to move £600m from predominantly rural areas to urban or less rural areas, the review said.

Pace of change

To avoid destabilising the system, CCGs are moved to their target allocations over time. Over the next five years, NHS England said the CCGs most below target will receive extra growth, to ensure no area is more than 5% below target.

Additionally, a group of 'typical' CCGs – those between -2.5% and +5% from target in 2019/20 and between 0% and +5% for all later years – will receive as close to average growth as possible. CCGs more than 5% above target will receive lower funding growth, tapering down to floor growth levels for those more than 10% above target.

For core CCG allocations, CCGs more than 10% over target will receive average growth minus 1.5 percentage points. While this is more generous than the previous allocation round, NHS England said it reflected higher assumed price and activity growth, as well as higher policy pressures in 2019/20. For primary care, these CCGs will receive 1.25 percentage points below average growth.

NHS Improvement makes asset sales change

Gains from asset sales will no longer be taken into account when assessing whether a trust has met its control total, following an announcement by NHS Improvement.

Trusts are encouraged to sell surplus assets. This generates cash for the selling organisation and, with capital tight to address backlog maintenance and support transformation, trusts have been urged to ensure they are identifying assets they no longer need.

Where there is a profit on disposal – selling price minus value of asset recorded in the statement of financial position minus costs of sale – this can increase any operating surplus or reduce a deficit.

In recent years, trusts reporting an improved financial position compared with their set control total have benefited from an increased share of sustainability funding – initially on a pound for pound basis.

There were a number of cases of trusts selling significant assets, which improved their financial position, triggering increased payments from the Sustainability and Transformation Fund (now the Provider Sustainability Fund, or PSF). This in turn triggered a further improvement in financial position.

While trusts were following the correct accounting treatment, NHS Improvement has amended this for 2019/20. 'Providers will not be able to use any of these gains to deliver their original 2019/20 control total,' it said in a letter.

The letter from Elizabeth O'Mahony, NHS Improvement's chief finance officer, notified providers of their control totals, which were described as 'stretching, deliverable and reflecting the distributional impact of the changes that have been made to the financial architecture of the NHS'.

O'Mahony: control totals 'stretching but deliverable'

The letter also confirmed that the ability to earn PSF in 2019/20 would be solely linked to acceptance and delivery of control totals. Currently, as long as control totals are met, 30% of PSF funds are linked to A&E performance.

A further letter to providers has added conditions to a specific bonus scheme linked to the PSF. Eligibility will now be partly based on the level of recurrent efficiency schemes delivered.

WAO urges tighter grip on agency bill

NHS Wales needs better data and strong leadership to tackle marked increases in agency spending, according to the Wales Audit Office.

Its report, *Expenditure on agency staff by NHS Wales*, said agency spending had risen by 171% in the past seven years, but acknowledged the service was trying to reduce demand and costs.

NHS Wales agency spending peaked in 2016/17 at more than £164m and the report said that, on average, health bodies spent around a third of their total agency spending on medical and dental locums, with a further third on nurses and midwives. Growing demand for staff and rising hourly rates charged by agencies have contributed to the rise.

The WAO said the service must get consistent and comparable data at an all-Wales level to track the volume, nature and cost of agency staff, together with the impact of mitigating interventions such as overtime and staff banks.

It also needed strong leadership to make difficult decisions, coupled with the capacity to drive change.

Auditor general Adrian Crompton hoped the report and a data tool the auditors have produced would be used 'to help NHS Wales continue to bring down and control these costs at a time of significant financial pressure'.

NAO: NHS must tackle demand

By Steve Brown

The NHS needs to secure a better grip of the demand for services and why it is occurring, as well as a new payment system that supports integration and greater clarity on the use of money to invest in new services, the National Audit Office said in January.

These were three recommendations from its report, *NHS financial sustainability*, which in part looked at the financial and operational performance in 2017/18. It noted that activity increased but waiting times continued to slip and performance against the A&E four-hour target fell to 88%. It would cost an extra £700m to reduce elective waiting lists to March 2018 levels, the NAO said.

The body highlighted large deficits in some parts of the system. Trusts and commissioners reported a combined deficit of £21m. But within this, providers collectively reported a deficit of £991m and clinical commissioning groups overspent by £213m – all offset by an NHS England underspend of £1,183m.

There is also significant variation in financial performance, with 100 out of 232 trusts in deficit and 10 trusts accounting for 69% of the net total provider deficit.

The watchdog said the operational and financial performance for the year 'does not add up to a picture we can describe as sustainable'.

It acknowledged the new financial settlement for the service and January's *NHS long-term plan* aimed to address the current pressures. It described the developments as 'positive' and the planning approach as 'prudent'. But it reserved judgement on whether the funding package could deliver the plan's ambitions until other elements of health spending were announced – covering Public Health England, capital budgets and clinical training funding – as well as social care funding plans.

'That money needs to be spent wisely and needs to address many of the challenges we identify in our report,' said NAO director of health value-for-money audit Robert White.

The report called on national bodies to test the realism of local plans to manage demand – had local bodies identified all their local drivers? Did they have capacity to meet demand? The payment system also needed to be simpler, have lower transaction costs and promote greater collaboration and management of demand.

NHS England and NHS Improvement should 'set out a medium-term strategy for redesigning tariffs', it said. The current review of capital should also examine how accessing capital can be simplified for all bodies, regardless of financial or statutory basis. It asked whether consideration should be given to restructuring balance sheets of trusts in severe financial trouble with loans unlikely to be repaid.

New NAO chief named

Gareth Davies (pictured) has been put forward as the next comptroller and auditor general of the National Audit Office. If recommended by the Commons and appointed by the Queen, Mr Davies will take up post in June, also becoming NAO chief executive. Sir Amyas Morse will continue to lead the NAO to the end of his 10-year term on 31 May. Mr Davies spent 25 years at the Audit Commission, becoming managing director of its audit practice, and was most recently head of public services at audit and advisory firm Mazars.

Northern Ireland chief calls for long-term funding

Richard Pengelly (pictured), the Northern Ireland Department of Health permanent secretary, has called for swift action to set the budget for 2019/20, although he warned that it would not be enough to tackle the demands facing the local health and social care (HSC) system.

He told a Commons Northern Ireland Affairs Committee hearing on health funding priorities: 'The sooner I get a budget for 2019/20, the sooner I can start to plan.

When I do get a budget, the one thing I can say with certainty is: I will view it as insufficient in terms of all the financial challenges I face.'

In the absence of an assembly and executive, the Northern Ireland Office set the budget for the current year in March 2018.

Mr Pengelly continued: 'I would not only welcome a budget for 2019/20; I would love a budget for the next two or three years to undertake that long-term planning. I think I could make bigger, more significant change in that context.'

Mr Pengelly acknowledged that break-even positions had been at the expense of waiting times, but clearing those lists would require additional funding and capacity.

In a Northern Ireland Audit Office report, comptroller and auditor general Kieran Donnelly said service transformation was required urgently.

'The health and social care system, as currently configured, is simply unable to cope with the demands being placed on it,' he said. 'As a result, far too many patients endured unacceptably long waiting times for treatment.'

He continued: 'My report makes the urgency of the reform agenda clear and emphasises the need for long-term financial planning in the health sector,' he added.

News review

Seamus Ward assesses the past two months in healthcare finance

The National Audit Office expressed 'shock' at the number of local bodies, including those in the NHS, that have received qualified audit reports. These qualifications reflected weaknesses in arrangements to secure value for money and not problems with financial statements, which were unqualified for the third year running. The value-for-money qualifications – issued to 168 (38%) of NHS bodies in 2017/18 compared with 130 (29%) in 2015/16 – were mainly the result of not meeting financial targets such as staying within spending limits, delivering savings or inadequate plans to deliver balance. The NAO's report added that 39% of clinical commissioning groups received a qualified opinion on the regularity of their 2017/18 financial statements because they had spent more than their allocations.

In a separate report, the NAO said many CCGs are performing well and within budget, but others are failing to function effectively or hire and retain the high-quality staff they need. *A review of the role and costs of clinical commissioning groups* noted that an increasing number of CCGs are overspending against their total budget plan. In 2017/18, 75 of 207 CCGs spent more than planned, with a total overspend of £213m across all CCGs. This compares with 57 CCGs in 2016/17 and 56 in 2015/16. However, CCGs have consistently spent less than their running costs funding, which fell from £1.35bn in 2013/14 to £1.21bn in 2015/16. It is planned that running cost allocations will reduce by a further 20% by 2020/21.

Patients fail to turn up to one in 20 primary care appointments, costing the NHS more than £200m a year and wasting more than 1.2 million GP hours, according to NHS England. It said more than 15 million appointments are missed each year, with patients not attending or failing to tell surgeries they will not be attending in time to reallocate the appointment. Around half of the missed appointments are with GPs – with each appointment costing an average of £30, failure to attend costs more than £216m. The national body urged patients to let surgeries know in good time if they are not able to attend.

A review of the GP partnership model recommended that funding for GP training places be increased, with a more positive focus given to general practice as a career choice during medical training. The review also recommended a reduction in personal risk and liability associated with GP partnership and called for a wider range of healthcare professionals to be embedded in practices to offer services in the community.

The Scottish government has proposed increases in health and care funding in 2019/20. In its Budget, it said it would use additional tax revenues, promised by the government in Westminster, to mitigate a £55m shortfall in NHS funding. Overall funding for revenue will be £13.9bn. The Budget document said frontline NHS board funding would increase by 4.2%. The Budget confirmed public sector pay would rise by 3% for those earning up to £36,500, while direct investment in mental healthcare would increase by £27m, taking overall funding of the sector to £1.1bn. It would also increase funding to health and social care partnerships to more than £9bn for delivery of primary and community health services.

In Wales, health board allocations for 2019/20 were announced. Health board discretionary allocations have increased by 2% (£92m) to meet estimated pay costs and other inflationary pressures. As in 2018/19, there will be a number

The month in quotes

'Our message is clear: if you cannot make it to your appointment or no longer need a consultation, please let your GP practice know in advance, so the appointment can be filled by another patient.'

Nikki Kanani, NHS England acting primary care director, makes a plea for patients to be considerate

'We're still in the early days of winter, and pressures are likely to increase further if cold weather or viral illnesses hit in earnest. If these pressures were to hit, this would make it harder for the service to improve performance and start implementing the long-term plan from April.'

Health Foundation policy fellow and GP Becks Fisher warns winter pressures could still impact on the NHS plan

'This award represents the hard work and dedication of colleagues in the trust who, day-in day-out, deliver fantastic patient care. I'd also take this opportunity to pay tribute to those staff I worked closely with in NHS Improvement and thank them, and all colleagues at Northumbria Healthcare, for their support and I accept this award in their collective honour.'

Jim Mackey accepts his knighthood

'I am shocked by the persistent high level of qualified audit reports at local public bodies. A qualification is a judgement that something is seriously wrong, but despite these continued warnings the number of bodies receiving qualifications is trending upwards.'

NAO head Amyas Morse is stunned by the number of value-for-money qualifications on audit reports

Former MoD director general nuclear Julian Kelly is the new CFO in the joint NHS England/ NHS Improvement senior team

of top slices to fund specific developments, with funding transferred to ring-fenced allocations or held centrally. An extra £45m has been added to the discretionary allocation to develop stronger integrated medium-term plans to take forward the strategy, *A healthier Wales* – this funding should be used to invest in primary care; embed value-based healthcare; take forward major strategic decisions; and improve quality.

Julian Kelly has been appointed NHS chief financial officer in the new joint NHS England and NHS Improvement senior leadership team. The joint group will be known as the NHS Executive Group and will be led by Simon Stevens and Ian Dalton. Mr Kelly will join the group from the Defence Nuclear Organisation at the Ministry of Defence, where he is director general nuclear. A chartered accountant with CIMA membership, he has also held senior roles in the UK Border Agency and HSBC. NHS Improvement chief financial officer Elizabeth O'Mahony is to become South West regional director. NHS Improvement announced a number of departures, including Adam Sewell-Jones, its executive director of improvement, and Stephen Hay, executive director of regulation and deputy chief executive. The departing executives will remain in post until the end of March, unless explicitly agreed otherwise.

Former NHS Improvement chief executive Jim Mackey – who is currently chief executive of Northumbria Healthcare NHS Foundation Trust and a former NHS finance director – was knighted for services to health in the new year's honours list. There were OBEs for HFMA Clinician of the Year in 2012 Malik Ramadhan, a consultant and divisional director in emergency care at Barts Health NHS Trust, and Angela Walsh, head of NHS pay at the Department of Health and Social Care.

The latest monthly performance figures for the NHS in England continue to show waiting time targets being missed in the face of mounting demand. In November 2018, 87.3% of patients had been waiting fewer than 18 weeks for elective treatment – it was 89.5% a year earlier – failing to meet the 92% target. However, the number of completed pathways increased by 0.4% over the 12-month period. In A&E, demand was 3.6% higher in the year to December than in the preceding 12 months. Data shows that 86.4% of patients were admitted, transferred or discharged within four hours, missing the 95% target.

NHS England and NHS Improvement have published the 2019/20 national tariff for its statutory consultation. The document confirms changes proposed towards the end of last year, including setting the tariff for a single year. A new blended payment system will become the default approach for emergency care, supported by a £1bn transfer from the Provider Sustainability Fund into emergency care prices. Prices will also be subject to a revised market forces factor, with the new MFF values phased in over five years. New procurement arrangements will be supported by a topslice to the tariff quantum.

hfma

from the hfma

Value and sustainability in the NHS can be delivered if finance professionals and clinicians come together, according to Professor Sir Muir Gray in a blog for the HFMA website. The value guru, who is the founding director of the Oxford Centre for Triple Value Healthcare, said the professional colleagues must foster an environment in which continuous value improvement becomes the norm. This must increase efficiency (or technical value) and also the two other elements of the triple aim – personal and population value.

Bill Shields (pictured), former HFMA chairman and NHS finance director, continues his blog series that follows his career as chief financial officer of Bermuda Hospitals Board. He reflects on a busy year-end, including starting the HFMA *Advanced higher diploma in healthcare business and finance* with a view to completing an MBA next year. The board is also progressing its change programme, including moving closer to an affiliation agreement with Johns Hopkins International and approving a strategic outline case for a public-private partnership to redevelop its estate. At the same time, the current system of health insurance could be replaced.

Also, in blogs, *Healthcare Finance* editor Steve Brown reflects on the HFMA annual conference in December. The event highlighted workforce as one of the key issues needing to be tackled in the *NHS long-term plan*.

• www.hfma.org.uk/news/blogs

HFMA 2018

Highlights from the conference in December

The *NHS long-term plan* was never far from the surface in presentations and sessions at December's HFMA annual conference. Although it was yet to be published – and delayed until January – it was inevitably going to dominate discussions on what it needed to contain to enable the NHS to meet demand and move towards sustainability.

Anita Charlesworth, director of research and economics at the Health Foundation, provided the context for the promised £20.5bn real-terms increase over the next five years. The average 3.4% increase was below the historic average of 3.7% and below the level needed to make modest improvements, according to work by the foundation and the Institute for Fiscal Studies. People had to be realistic about what could be achieved, she said.

Ian Dalton, NHS Improvement chief executive, also looked ahead to a plan that would need to drive improvements in the provision of outpatients, early diagnosis of cancer and the care of the elderly – while eliminating the provider deficit and reducing unwarranted variation generally. He told the conference system-wide working would need to be the norm and not an option.

A panel session highlighted the importance of the plan being credible and creating a sense of hope. Claire Murdoch, chief executive of Central and North West London NHS Foundation Trust and national mental health director for NHS England, said there needed to be a 'belief things can change'. Rebecca Rosen, GP and senior fellow at the Nuffield Trust, sought recognition of the time needed to make transformational changes.

The conference also turned the focus on the NHS finance function and how it could increase diversity in its senior leadership. Highlighting a new NHS Improvement programme – *Going beyond* – Sandra Easton, chief finance officer of Chelsea and Westminster NHS Foundation Trust, said there was diversity in the workforce as a whole, 'but we are not pushing or pulling them up'. Sponsorship would be part of the solution.

The conference showcased the best in NHS finance and governance in the annual HFMA Awards. Among eight awards, Kathy Roe, finance director for public services in Tameside and Glossop, was named Finance Director of the Year (see HFMA Awards 2018 supplement at www.hfma.org.uk). The association also celebrated the achievements of 41 students who completed diplomas and certificates as part of the HFMA's masters-level qualifications programme (page 26).

Outgoing HFMA president Alex Gild

Anita Charlesworth spelt out some economic facts

Incoming HFMA president Bill Gregory

Former health minister Norman Lamb

Panel session on the long-term plan

HFMA AWARDS 2018

Professor Tony Young, NHS England's national clinical lead for innovation

The conference included a series of short, fast-paced talks

Double Olympic gold medal-winning boxer Nicola Adams

Ian Dalton, NHS Improvement chief executive

Panel session on improving diversity in senior NHS finance roles

Students receiving certificates as part of their HFMA level 7 qualifications

CONFERENCE PHOTOGRAPHY: THEODORE WOOD

Comment

February 2019

Finance's key role

The NHS long-term plan sets direction, but there is an opportunity to shape the detail

HFMA president Bill Gregory

The news about the NHS at this time of year is normally dominated by A&E pressures and waiting times. While our frontline teams have done a sterling job in dealing with these pressures through the Christmas and new year period, it was good to see the Brexit fog lift for a couple of weeks and the positive media speculation about the contents of the *NHS long-term plan*. We need speculate no longer! January saw the publication of not only the plan but also the detailed planning guidance for 2019/20. The plan is an opportunity to reset the direction of healthcare delivery and development, following a very difficult period in the NHS's history. It certainly points the way for a health service for this century.

Often NHS resets are accompanied by significant restructuring plans. And while the long-term plan indicates changes to the commissioning landscape and confirmation of the importance of new regional teams, rightly its main focus is on improving patient outcomes and experience.

From a resources point of view, the continuing focus on reducing unwarranted variation and effective use of resources is clear. The initiative to look at reducing unnecessary outpatient appointments is something that ticks all the boxes – quality, experience and resources. I am sure many of us have attended hospital and GP appointments and wondered if the appointment

Questions, questions

The new NHS plan raises multiple questions and implies wide-ranging programmes being delivered in parallel

Healthcare Finance editor Steve Brown

The NHS long-term plan provides clarity about the direction the NHS is moving in. Integrated care systems are the future and there must be a rebalancing of services – both from treatment to prevention and from acute to the community and primary care settings.

Few, if any, would argue against these ambitions. But stating them is one thing, realising them is an altogether bigger challenge.

There are huge questions looming over the plan. The obvious high-level ones remain to do with funding and workforce. Despite commitments to increase clinical placements for nursing and expand medical school places – the first steps in three- and five-year journeys to increase home-grown capacity in these vital areas – we don't yet know the training budgets for the years ahead. We will have to wait for the spending review later in the year to address these major uncertainties.

Long-term capital budgets are similarly unknown. Some challenges bring together these two issues – staff and capital – that are so vital to the plan's delivery. The plan acknowledges we have fewer MRI and CT scanners per head than most OECD countries. And vacancy rates for radiologists and radiographers are 12.5% and 15%. Yet

referrals for diagnostic tests have risen by over 25% in five years.

Imaging networks are the plan's response – and investment in a 'new digital diagnostic imaging service'. As with most aspects of the plan, the NHS is not starting from scratch. Four early adopter imaging networks were selected last year (from 22 expressions of interest, which shows the local enthusiasm to improve). But getting from the current underprovided service to one where diagnostics meet demand and support revised pathways is a huge transformation in its own right.

The acceleration of integrated care systems

"The initiative to look at reducing unnecessary outpatient appointments is something that ticks all the boxes – quality, experience and resource"

could have been delivered as effectively by phone or email.

I believe this outpatient initiative has the potential to go way beyond this, using technology and patient peer support to monitor disease progression over time. This is fertile ground for deploying the concepts of value-based healthcare to evaluate improvement in outcomes and costs as these changes get implemented.

As expected, the planning guidance sets out the arrangements for a transition year, but is a step in the right direction towards putting the whole NHS back on a sustainable footing. There is excitement about the size of the clinical commissioning group allocation uplifts. But while there will be new money, we should not forget they will also include the system impact of the market forces factor changes and sustainability funding being fed into the tariff.

Provider sustainability remains a key priority, and the combination of the payment mechanism changes and tariff increases for emergency care should help acute providers. The establishment of the fund to support 'essential services' in deficit providers should also give new regional teams the opportunity to incentivise local improvement plans.

Similarly, sustainability and transformation partnership and integrated care system control totals should give organisations further incentive to work collaboratively as an integrated system.

As part of my *Value the opportunity* theme for my year in office (see page 16), I have talked about the HFMA helping to shape and influence the financial architecture. There is still much to be landed in this transition year – capital, particularly backlog maintenance in providers; influencing how the public health grant is deployed; and managing competition in an integrated health system.

Our members can and should help to shape approaches in these areas for the future. It is a challenging agenda – locally and nationally – but the finance function has a key role in it. We have the opportunity to add value – and we need to take this chance.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

also raises questions. Promising that ICSs will cover the whole country by April 2021 shows a welcome commitment to managing on the basis of population health. But moving beyond the current sustainability and transformation partnerships – where progress is at very different stages – will need much more than setting a deadline. The most advanced ICSs have a history of system collaboration that doesn't exist everywhere.

The plans to return all NHS providers to financial balance by 2023/24 also appear ambitious in the face of the current financial position, providers' underlying deficit of £1.85bn and significant continuing demand and activity pressures. The service needs to understand much more about how the new proposed financial recovery fund – aimed at deficit providers – will work, given that the more broadly focused provider sustainability fund is being phased out.

There are wide-ranging questions at more detailed levels too. As part of 10 areas prioritised for special attention in driving efficiency, the plan wants all providers deploying clinical staff using an electronic roster or e-job plan by 2021. Again, this is nothing new – there have been frequent calls for this, perhaps most recently in the Carter report on provider productivity. But the plan envisages trusts doing more than investing in systems – many trusts already have them – and starting to use them in a meaningful way for medical as well as nursing staff.

There is an undoubted value to be had in this area – but such changes will not be switched on overnight.

Also in the efficiency section, the plan talks about realising £700m savings in administrative costs. This will come from an overhaul of the 'overly bureaucratic contracting processes, supported by reforms

"The plan was necessary. But there can be no doubt that the real work starts now"

to the payment system'. This has been a long time coming and will take concerted central and local action. And a throw-away line about automating all core transactional services, including processing invoices, sounds like we can expect some major progress on e-invoicing and perhaps even a different approach to dealing with low-value invoices (*Traffic control, Healthcare Finance, December 2018, p19*).

The long-term plan was a necessary summary of where the NHS needs to be heading – adding some new promises and pulling together existing initiatives and aims into a single document. That has been helpful. But there can be no doubt that the real work starts now. There needs to be clear recognition of the scale of the task facing local health economies.

But success will also rely on the government putting the right funding in place for the wider NHS budget and social care budgets and delivering much needed detail on how the plan can move forward.

HFMA e-learning
Healthcare finance and business training

HFMA e-learning

Improving performance through a better understanding of the NHS

Find out how you or your organisation can access HFMA's e-learning

hfma.to/elearning
0117 938 8323
info@hfma.org.uk

Thank you to all HFMA corporate partners for their continued support

3M · abbvie · BROOKSON DIRECT · infor Healthcare · CIVICA
prime · selenity expenses · fleet SOLUTIONS · GENMED · GETINGE
Grant Thornton · IMS Health & Quintiles are now IQVIA · Johnson & Johnson MEDICAL DEVICES COMPANIES · STORZ KARL STORZ – ENDOSKOPE
LIAISON · NHS Improvement · NHS Shared Business Services · ORACLE · Meridian

hfma Corporate Partner

For more information about becoming a corporate partner, please contact
Paul Momber **E paul.momber@hfma.org.uk T 0117 938 8972**

Community chance

Many areas already have social prescribing programmes in place, but the NHS long-term plan wants to expand the practice so that it is universally available. Steve Brown reports

Social prescribing is not a new phenomenon. It has been practised in an ad hoc way for a long time, though people tend to point to a 1990s scheme in Bromley-by-Bow as the first example of a formal scheme. But it has been growing in profile over the last few years. Fitting neatly with increasing moves towards personalisation, it is listed as one of the 10 high-impact actions in 2016's *General practice forward view*. And now the *NHS long-term plan*, published in January, looks set to bring social prescribing into the mainstream.

Social prescribing enables GPs or other healthcare professionals to refer patients to a non-clinical link worker. This link worker spends time with the person so they can work out together what their needs and goals are and then refer them on to activities, voluntary groups or local schemes to help address those needs. This may tackle some of the patient's social needs – such as loneliness or social isolation – which in turn contribute to their well-being.

It is perhaps a bit 'touchy feely' compared with emergency and acute treatment of patients – but it is increasingly seen as having the potential to make a big difference to patient outcomes – or avoiding ill health – and to the costs of healthcare delivery. The fact that it is being taken extremely seriously is underlined by its inclusion in January's long-term plan.

The long-term plan names the approach as a key component in its attempts to rebalance the NHS more towards prevention and supporting people to manage their own health and conditions. Rather than the current piecemeal approach to social prescribing – universal services in some areas, no social prescribing in others – it will become 'accessible across the country' in the next five years. 'Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then,' the plan says.

Devon GP Michael Dixon, NHS England's national champion for social prescribing, told the HFMA annual conference in December that social prescribing had the potential to change the face of general practice and primary care within the next five years.

In many ways, it could pick up a role played by GPs before demand increased, when they could spend more time with patients. And it provides a response that is better suited to addressing socioeconomic or psychosocial issues than many medical interventions.

It has been estimated that about 20% of patients consult their GP for what is primarily a social problem. And while it can be used to meet the needs of people with wide-ranging issues, it has particular relevance for those with mild mental health conditions, such as depression, or long-term conditions.

"Social prescribing creates a virtuous circle whereby the patient instigates their own improvement and isn't relying on [the medical] profession"
Michael Dixon, NHS England (pictured)

Dr Dixon believes the NHS often takes an 'over-medicalised' approach – a medical response to a young new mother feeling isolated and unhappy might be to offer antidepressants or refer for a psychiatric intervention. But in many cases, social prescribing might offer a solution that addresses the causes not the symptoms.

'It can create not only a cheaper alternative and a better alternative in terms of sustainability,' he says, 'it also creates a virtuous circle whereby the patient instigates their own improvement and isn't relying on [the medical] profession.'

Link workers – sometimes known as health advisers, community navigators or wellbeing co-ordinators – are key to the social prescribing model. They need to engage with referring professionals, the referred people and the local voluntary, community and social enterprise sector. Once they have received a referral, they will spend time with the patient and co-produce a solution to address identified issues. This could involve matching the person to a local activity or service from a menu of local options – advice, theatre or walking groups, exercise classes or art/gardening sessions, for example – and perhaps even accompanying them to their first session.

Outcomes often claimed for social prescribing schemes include improved self-confidence and employability, better lifestyles, reduced isolation and patient 'activation' – alongside improved community resilience and reduced costs across the care pathway. Dr Dixon cites growing economic evidence – a 20% reduction in hospital and GP attendances. 'Across schemes in Gloucestershire, Rotherham, Frome, West London and Croydon, it is a fairly consistent figure with the sites all producing good statistics in the last year,' he says.

A formal review of the impact of social prescribing on healthcare demand and cost by the University of Westminster – published in 2017 and on the Social Prescribing Network website – supports this claim. 'The evidence for social prescribing is broadly supportive of its potential

Culture shift

Adopting social prescribing across Gloucestershire required a shift in culture for many GPs and a swing towards encouraging prevention and self-care, according to Jo Bayley, primary care representative on the county's integrated care system delivery board.

She suggests social prescribing enables health professionals to view individuals through a social lens, recognising how social factors influence their health and wellbeing. Opportunities offered include: art; exercise; learning new skills; volunteering; befriending; and self-help; as well as support for issues such as work, benefits, housing and debt.

A 'social prescribing plus' scheme is also developing specific, targeted interventions to help treat psychosocial aspects of medical conditions. 'For example 50% of chronic obstructive pulmonary disease patients do not attend pulmonary rehab because it is exercise based,' says Dr Bayley. Thinking some of these people might benefit from getting involved with a choir, commissioners worked with local charity Mindsong to develop a 12-week 'singing on prescription' scheme. Participants will be supported to progress to a generic community choir once breath control and confidence improves.

A social prescribing pilot in 2014/15 also saw a 23% decline in A&E admissions and 21% fall in GP appointments alongside improved mental wellbeing scores. Independent evaluation suggested an estimated return on investment of £1.69 for every £1 spent (health £0.43; social £1.26). More recently a community wellbeing service has been launched with the county council to combine social prescribing with community capacity building with nearly 3,000 referrals in its first year – mostly related to stress and worry.

to reduce demand on primary and secondary care,' it concludes. Looking at published reports on UK schemes, it found an average reduction in demand for GP services of 28% following referral and an average fall in A&E attendance of 24%. However, it warns that the small number of reports involved and the quality of data meant that the results needed to be interpreted with caution.

Rotherham Clinical Commissioning Group adopted social prescribing back in 2012, when the commissioner's third sector partner Voluntary Action Rotherham (VAR) put a clear business case proposal to the CCG. The business case had benefits that would meet service delivery targets – improving patient/user health and wellbeing – and result in finance benefits, primarily reducing hospital admissions and A&E attendances. Following a successful pilot, it was recommissioned, with funding in recent years coming from the Better Care Fund.

VAR acts as a social prescribing broker. 'It runs the scheme for us and we do all the contract monitoring via VAR,' says Ruth Nutbrown, the CCG's assistant chief officer. 'We give it grants that allow it to spot purchase from the voluntary and community sector so we are putting money into the sector and supporting its resilience in Rotherham.' VAR has also developed a system of micro-commissioning services from the voluntary and community sector. It acts as the lead contracting body and subcontracts with over 20 different organisations.

VAR link workers refer patients onto non-clinical services ranging from benefits and housing advice to lunch, dancing and fishing clubs. Ms Nutbrown says the services are a mix of existing voluntary services that can be referred to 'without cost' and ones where services need to be spot purchased or where pump priming funds are needed.

But often the funds are small in comparison to NHS commissioning budgets. '£500 can make an awful lot of difference, sustaining a group for years in some cases,' Ms Nutbrown says. 'Quite a lot of the grants are that sort of money – to small local Rotherham groups.

Risk stratification tool

'The scheme uses a risk stratification tool to identify those people most likely to attend A&E or be admitted to hospital and GPs will put patients forward for a referral in multi-disciplinary team meetings,' she adds.

An evaluation of the long-term conditions scheme in 2016 reinforced earlier assessed benefits. It found reductions of 7%, 11% and 17% in non-elective inpatient episodes, non-elective inpatient spells and A&E attendances. And these reductions rose to 19%, 20% and 23% when the over-80s were excluded. Progress was also made against outcome measures looking at areas such as lifestyle and managing symptoms.

Estimates suggested that NHS costs avoided could be as high as £2 for every £1 invested after five years and before benefits from improved service user outcomes were factored in.

Following the success of the scheme, the CCG started a parallel scheme focused on mental health in 2015 – aimed at supporting discharge from secondary mental healthcare services. It is run in partnership with Rotherham, Doncaster and South Humber NHS Foundation Trust and VAR. This scheme focuses on three service user care pathways: cluster 4 (severe depression and anxiety); cluster 7 (long-term anxiety and depression); and cluster 11 (history of psychotic symptoms, in recovery but needing to regain confidence).

A transition pathway has been developed to support users moving from mental health services to social prescribing activities and discharge – broken down into three separate phases. The social prescribing activities commissioned fall into four broad themes: befriending; education and training; community activity; and therapeutic services.

Two-year evaluation

An evaluation of the first two years of the service was extremely positive. More than 90% of service users made progress against at least one outcome measure. Some gained employment or had sustained involvement with voluntary sector activity. And more than half of the users eligible for a discharge review were discharged from secondary mental health services – a very positive result considering some patients had been supported in secondary care for between five and 20 years.

If discharge can be sustained for at least a year, the evaluation suggested 'potential for the service to provide fiscal and economic return on investment', with this return increasing if benefits for non-discharged patients are also taken into account. Wellbeing benefits were estimated to equate to a social return on investment of £1.84 per £1 invested.

The mental health scheme involves smaller numbers of patients than the long-term conditions scheme as it focuses on breaking the cycle of appointments and admissions for patients already in the system. Often the users are also much younger. 'But we have results where we have actually got people back into work,' says Ms Nutbrown.

The scheme is also a victim of its own success as referrals are dropping as the numbers of people 'stuck' in the system fall. 'So we are looking to transform the scheme and upstream it to have a focus on prevention,' she adds.

Last year the government awarded a share of £4.5m to 23 social prescribing projects to extend schemes or establish new ones – as part of a voluntary, community and social enterprise health and wellbeing programme. The funding runs for one-year with additional joint funding from local commissioners to be agreed for the subsequent two years.

The new expansion plans unveiled in the NHS plan suggest far more money will need to flow into social prescribing – both to create the link worker infrastructure and to support the development of community groups and programmes.

Baxter

Taking Healthcare Home:
Realising the value of empowering patients to manage their own treament

It is well known that the NHS faces challenges in meeting the growing demand for healthcare within its available resources. With life expectancy increasing, the rising trend in prevalence of co-morbidities, and the expanding expectations of the public for convenient and personal care, NHS costs are becoming unmanageable and the pressure to reduce costs is ever growing. Demand is rising at a rate of 4 per cent, whilst current funding growth remains at just 1 per cent. In order to achieve the £22 billion efficiency savings of the NHS Five Year Forward View by 2020, the momentum to drive new models of care must gain pace. This is further defined in the NHS Long Term Plan setting out how the NHS will move to a new service model in which patients get more options, better support and properly joined up care at the right time in the optimal care setting.

Out of hospital care offers significant opportunities to both generate efficiency savings and improve quality and safety of care. Home therapies can empower patients to take control of their own treatment, drawing on clinical and other support to assist their choices. However, budgetary silos between different NHS organisations and local government often act as a barrier to enabling increased out of hospital care.

Baxter is a leading supplier of products and services to the NHS, supporting patients at all stages from hospital admission to managing a long term condition at home. There are evident examples of how Baxter can help the NHS deliver the out of hospital care agenda set out in the Five Year Forward View.

Outpatient Parenteral Antimicrobial Therapy (OPAT) allows patients who are on IV antibiotic therapy and medically stable, to be treated in an outpatient setting rather than being admitted to hospital when that would be the only reason to admit them. Nationally there are approximately **500,000 patients** every year who solely require IV antimicrobial therapy administered within NHS hospitals[1,2]. This equates to the use of about **9 million bed days** across the NHS on an annual basis[3]. Currently this pathway costs the NHS **£2.7 billion** on bed day costs alone, without accounting for unwarranted variation across the country[4].

Moving these patients into the community on OPAT would cost the NHS around £500 million. This assumes an equal split between patients self-caring and patients receiving nursing support at home. Treating this group of patients on OPAT would result in an efficiency saving over £2 billion*.

**(The estimated cost saving does not account for other potential efficiencies and cost reductions such as reduced rates of hospital-acquired infections due to shorter hospital stays[5], better patient experiences[5] and reduced inpatient bed use within hospitals[5]; thus freeing up capacity).*

Renal dialysis is an example where product innovation supports treatment at home, offering patients better clinical outcomes and improved **quality of life.** Improved rates of home therapies are possible and there is a need to reduce variation between providers. Baxter's cloud-based communication platform that connects home dialysis devices to Renal Units enables clinicians to monitor their patients remotely. This simple technology is a step change in innovation and has the potential to increase both patients' and clinicians' confidence and **reduce avoidable and costly hospital visits.**

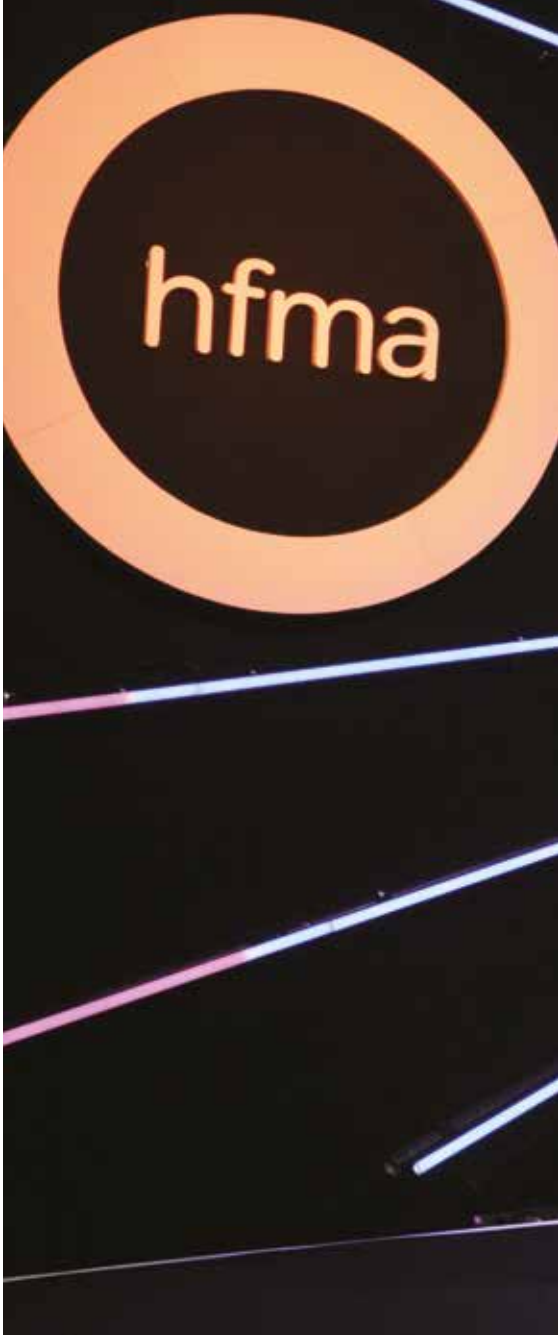
The Baxter Evolving Heath Programme partners with the NHS to deliver the quality and efficiency agenda, maximising value across the patient pathway. If you would like to find out more about our Evolving Health Programme and how Baxter can work with you in your local health economy then please give our Evolving Health team a call on **01635 206084**

evolvinghealth™
PATIENTS • QUALITY • EFFICIENCY

References: 1. Based on HSCIC Hospital Episode Statistics, April 2014 – March 2015. Admitted Patient Care: FCEs excluding day cases. 2. Chapman A. 2013. Outpatient Parenteral Antimicrobial Therapy in a Changing NHS: Challenges and Opportunities (Up to 4% of hospital admissions solely for IV antimicrobials). 3. Chapman A, et al. 2009. Clinical efficacy and cost effectiveness of outpatient parenteral antibiotic therapy (OPAT): a UK perspective. (Mean duration of therapy: 22.5 days). 4. Lord Carter, 2016. Operational productivity and performance in English NHS acute hospitals, pg. 66 (Estimated cost of hospital bed day: £300). 5. Barr D.A, Semple L, Seaton R.A, 2012. Outpatient parenteral antimicrobial therapy (OPAT) in a teaching hospital-based practice: a retrospective cohort study describing experience and evolution over 10 years.

UKI/MG9/19-0002

A clear focus on opportunity



New HFMA president Bill Gregory wants the association to focus on influencing policy, promoting value-based care and professional development. Seamus Ward reports

It's almost become a cliché, when a new HFMA president takes office, that they will spend a year leading an embattled NHS finance profession doing its best to balance the books, while their organisations face ever-increasing demand as they try to find time to transform services. This year will see the new money promised in the five-year financial settlement begin to flow, but in England the *NHS long-term plan* and planning guidance for 2019/20 expects the extra funding will produce quick results – for example, reducing the number of deficit trusts by 50%. The outlook may appear challenging, but new HFMA president Bill Gregory sees reason for optimism.

'The long-term plan is a welcome reset after a challenging and difficult time, which has lasted five years or more both for the NHS and finance professionals,' he says.

'I am quite pleased about the emphasis on outcomes rather than getting hung up about the structures. Reorganising might enable us to reorientate our thinking, but it won't solve our problems – we have to achieve that reorientation in other ways.'

Mr Gregory, chief finance officer and deputy chief executive of Lancashire Care NHS Foundation Trust, also backs the move to blended payments in urgent and emergency care, and the scrapping of the marginal rate emergency tariff and 30-day readmission rules.

'I found the focus on reducing unnecessary outpatient appointments fascinating. That's fertile ground for value-based healthcare because I suspect many of us have been to a hospital appointment and thought, "Why was that not done in the local GP surgery or by phone?". The real prize will be gained when replacing the current outpatients system with alternatives – the question will be, are the alternatives more efficient and what will the outcomes be? This is good territory for value.'

Public health data could be used to plan services in the future. 'That really resonates with value and using data alongside financial information to work out the best thing to do.'

He adds that more work is needed on the role the NHS will play in decisions on spending the public health grant – the long-term plan said government and the NHS would consider giving the health service a greater role in commissioning sexual healthcare, health visitors and school nurses. Mr Gregory believes this must be handled carefully as it could become contentious, especially given the financial pressures on council social care. 'It's an area where there is the potential for disintegration rather than integration,' he adds.

Equally, he sounds a note of caution about the clinical commissioning group allocations for 2019/20. 'There was some excitement about the size of some CCG allocations, but we need to be cautious. There is some differential compared with the current year, but there have been changes to the allocations, the market forces factor has changed, and these will affect the system differentials.'

Changes to the allocation of the provider sustainability fund, including the transfer of £1bn from the fund into urgent and emergency care prices, have also affected the new allocations. 'Quite a bit of any increase will be due to sustainability funding, which will come through allocations, as well as funding around pay awards. When integrated care systems (ICSs) do their plans, it will be important to see the underlying growth in resources. I suspect they will probably not be as big as the headline figures,' Mr Gregory adds. 'The move to get providers collectively back in balance within two years is a positive step, but we will still need to understand how that will work.'

National bodies have dubbed 2019/20 a transitional year, and Mr Gregory is looking forward to playing his part as HFMA president. 'It's a real privilege to be a trustee and also president of the association. It gives me an opportunity to put something back in, particularly after a number of years of benefiting from the networking and the personal and professional development offered by the HFMA to its members. It feels the right thing to do, and an honour to be asked.'

He continues: 'I am most looking forward to getting out there and visiting the branches. I

"We in England have a lot to learn from integration in Scotland, Wales and Northern Ireland"

have been a trustee for about three years, so I have a fair understanding of the mechanism of head office. I've met some branch chairs who have come to trustee meetings, but apart from the North West Branch events, I've not really been able to get out to the branches. I want to get a sense of what people are thinking around the new long-term plan for England. It will also be an opportunity to meet the finance leaders of the future.'

UK-wide awareness

Though, naturally, a lot of attention this year will be paid to the long-term plan for England, Mr Gregory is keen to ensure voices from the three devolved nations are heard. 'All the other nations have integrated systems of varying structure, but are still facing similar service challenges and pressures to those being experienced by the English system. I am sure that we in England have a lot to learn from integration in Scotland, Wales and Northern Ireland. Having integrated systems does not resolve all the problems. But it does give you a more joined-up way of looking at the problems and finding solutions.

'The devolved nations have a big part to play in the English system learning from what's happened there. But, as the English system evolves, there will be learning for the devolved nations as well. I think the four-nation focus is a real strength of the HFMA and it's really important we continue with that.'

Mr Gregory's theme for the year is *Value the opportunity.* It has three elements – influencing the agenda; focusing on value to improve patient care; and professional development.

Though the long-term plan for the NHS in England has been published, Mr Gregory believes the HFMA can continue to influence how it develops. He points to unanswered questions – on control totals or the use of public health grant, for example. The association is talking to NHS England and NHS Improvement about how it can help work through outstanding issues.

'The long-term plan sets out a useful direction of travel and, together with the one-year planning guidance, is clearly a step in the right direction,' he says.

But 2019/20 will be a transitional year and there are questions around areas such as additional funding, control totals and nuances in the tariff.

'There is still quite a lot to be worked out, not least the issues around ICSs becoming the level of local planning in the NHS. This work includes hammering out the detail of the operation of system control totals. There are still some things that need to be fine tuned for 2019/20.'

There are other questions, he adds. 'How does the NHS influence how the public health grant is spent and how do you deal with competition in an integrated environment? The things that would stop us making progress have been addressed for 2019/20, but in the longer term some things need to be clarified.'

The long-term plan does not deal with


hfma
HFMA publications
Independent research and analysis on healthcare finance and governance.
Check out our reports, blogs, briefings and guides on hfma.to/hfmapublications

A career in finance

Bill Gregory has worked in the NHS for most of his career, joining the then NHS Executive in the North West in 1993. He came from private practice and has spent all but two of the past 25 years within the health service.

He is a fellow of both ACCA and the ICAEW – qualifications gained after his degree in mathematics and management science from the University of Hull. In 2012, he was awarded an MBA from the University of Manchester.

Mr Gregory enjoys an active lifestyle, including walking and cycling, and is married with two daughters at university. Since 2014, he has been a co-opted member of the Lancaster University finance and general purpose committee.

His CV includes:

- Lancashire Care NHS Foundation Trust: chief finance officer and deputy chief executive, February 2015 to present
- Stockport NHS Foundation Trust: director of finance and deputy chief executive, June 2007 to January 2015
- Sherwood Forest Hospitals NHS Trust: director of finance, November 2003 to May 2007
- BUPA Hospitals Limited: head of NHS business development, October 2001 to October 2003
- Liverpool Heart and Chest Hospital (previously The Cardiothoracic Centre NHS Trust): director of finance and information, July 1996 to October 2001
- South Cumbria Community and Mental Health NHS Trust: director of finance and information (seconded from NHS Executive North West), May 1995 to June 1996
- NHS Executive North West: assistant director of finance, November 1993 to April 1995
- Coopers and Lybrand: management consultant, April 1989 to October 1993
- ATOS (previously Sema): project manager, September 1986 to March 1989

capital – instead, saying capital funding will be dealt with in the forthcoming spending review. Mr Gregory points out that, in the meantime, the NHS has a major maintenance backlog.

The HFMA influencing agenda will not be restricted to the NHS long-term plan. Some workshop events, initially created under 2018 president Alex Gild's theme, *Brighter together*, will be held this year and focus on system working and integration.

'One of the things to focus on in this area is the information we need to operate more effectively as systems,' Mr Gregory says.

Value-based care

The second element of his theme seeks to improve patient care by increasing the focus on value-based healthcare. The NHS long-term plan's vision of system working could create new opportunities for the HFMA value work, which is carried out by the Healthcare Costing for Value Institute. 'The long-term plan vision almost cries out for value-based healthcare techniques and tools,' he says. 'When you are moving from working at an organisation level to working as a system, it potentially becomes easier to talk about the whole pathway. The time has come for the work the institute has been doing and will be developing.

'For example, outpatients with cardiac outpatient appointments are quite often on six- or 12-month recalls to see their cardiologist. That happens for good clinical reasons, but could it be done differently? Could primary care be supported to do it? It would shift funds around the system, but you would also have to ensure that the outcomes, at the very least, do not deteriorate. Hopefully, outcomes for patients and patient experience will be better.'

In his speech to the HFMA conference in December, Mr Gregory mentioned the institute working with Matthew Cripps and his team at NHS England on programme budgeting. The current programme budgeting tool allows, for example, comparison of costs across disease groups by CCG.

Returning to this theme, he says: 'There are lots of issues around the programme budgeting tool, not least of which is the fact that how it gets deployed on the ground varies across the country. NHS England is keen to make it a more useful tool and the institute is working with Matthew Cripps and his team on that.'

Mr Gregory is looking forward to the institute/Future-Focused Finance value summit in May. 'The theme of the summit is how finance professionals and clinicians are working together to use value to solve problems – it's an opportunity for institute members to showcase work they are doing.'

Development focus

Professional development is the third element of Mr Gregory's theme and the HFMA qualifications will be central to this. 'At conference I mentioned that most of us will be members of professional accountancy bodies, which gives us the licence to practise as accountants. But the HFMA provides us with sector-relevant development and expertise in healthcare. I think the higher-level qualifications will be valuable to individuals keen to further their career or change roles within the sector.

'They will help introduce them to wider issues and are already beginning to mark out individuals seeking new opportunities.'

The association's introductory level qualifications could provide a step-up for those new to NHS finance or hoping to develop their career through an apprenticeship. 'The next step with the qualifications is how we can harness the power of the apprenticeship funding,' says Mr Gregory. 'Could we make sure we are offering something that's relevant to people who are not yet qualified? The ideal solution would be a programme that accesses the resources of the apprenticeship scheme and also offers the option to progress to gaining a full professional qualification.'

Mr Gregory wants the association to continue to develop its offering to current and future finance professionals, supporting their career development and helping shape the policy environment in which they work. For the HFMA and its members, he believes, opportunity knocks.

system reset

Joined-up services, driven by blanket coverage of integrated care systems, are key elements of the NHS long-term plan for England. Seamus Ward reports

Over the last few years, NHS leaders have stressed the importance of collaboration and integration. Under 2014's *NHS five-year forward view*, vanguards explored closer ties between individual providers, and between commissioners and providers. New ideas emerged, such as the aligned incentives contract, which promotes shared financial responsibility between local NHS organisations, and innovative governance arrangements, including joint management structures for all local NHS and council commissioning. The new *NHS long-term plan* aims to formalise collaboration, making it mainstream and not just something done at the margins.

Integrated care systems (ICSs) will be the driving force behind this. They will become the basic unit of financial planning and service prioritisation, with commissioners and providers working together to make joint decisions. The plan says ICSs will cover the country by April 2021, potentially precipitating more clinical commissioning group mergers – typically, there will be one CCG per ICS, the plan says. The plan acknowledges that systems will be at different levels of maturity and national support will be provided to help developing ICSs.

ICSs will be charged with delivering what the plan calls a new service model for the 21st century – boosting out-of-hospital care and ensuring there are no barriers between primary and community services. Out-of-hospital services will receive at least £4.5bn more by 2023/24.

ICSs will be responsible for reducing unwarranted variation locally

Workforce – key issue, main risk

The National Audit Office's *NHS financial sustainability* report last month highlighted workforce as a key risk to delivering the long-term plan, *writes Steve Brown*. While NHS England funding has been set for the next five years, we have yet to see the all-important plans for clinical training budgets. It also warned that the NHS could find itself unable to spend the average 3.4% real-terms increase optimally because of existing staff shortages.

The *NHS long-term plan* – while confirming that the NHS will have to wait for a workforce implementation plan until later in the year – does at least acknowledge there is a serious issue. While it says there will always be a 'background number of vacancies', the current situation is 'unsustainable'. NHS Improvement has reported that there are more than 100,000 vacancies, including 41,000 nursing and 9,300 medical posts.

Workforce planning has been too disjointed. Many would argue that the timing of the end to nursing bursaries, coupled with the massive uncertainty created by the government's handling of Brexit, suggests this planning has been non-existent. The NHS plan highlights that more applicants were accepted onto English nursing courses last year than in seven of the past 10 years. But it acknowledges that turning away an additional 14,000 applicants at a time of staff shortage is 'to say the least paradoxical'.

On nursing, the plan promises to increase nurse undergraduate places by 25%, aided by a 25% increase (an extra 5,000) in the number of funded clinical placements in 2019/20. From 2020/21, this will rise to up to 50%. And every graduating nurse or midwife will be offered a five-year NHS job guarantee in the region in which they qualify.

A 50% increase in the number of new nursing associates, delivered through nursing apprenticeships, should help the service to invest half of the £200m apprenticeship levy back into the NHS next year. Apprenticeships will also be expanded more generally in clinical and non-clinical roles, with an expectation that all entry-level jobs will be offered as apprenticeships before considering other recruitment options.

It is less clear how the centre aims to meet commitments to address shortages in specific allied health professional roles – paramedics, podiatrists, radiographers and speech language therapists, for example.

Medical school places will also grow from 6,000 to 7,500 a year. However, given

SHUTTERSTOCK

and they will be expected to bring together clinicians and managers to introduce appropriate evidence-based care pathways.

Crucially, ICSs will be supported by a raft of operational and financial policy changes designed to ensure they succeed. The provider financial framework will be reset to encourage system working. Control totals are being rebased for 2019/20 and central 'grip' is due to be relaxed – financial oversight via control totals will be dismantled from 2020/21 as and when individual providers return to financial balance.

ICSs and sustainability and transformation partnerships (STPs) will be given greater freedom to change the control totals of individual organisations within their systems to improve operational and financial performance. However, this must be financially neutral, with the system control total remaining unchanged.

Collaboration will deliver system affordability, with trusts and commissioners agreeing the services to be provided and the reasonable costs that will be incurred to do so.

As ICSs develop, they will be allowed to take on more responsibilities for wider objectives in relation to the use of NHS resources and population health. As they will be working in partnership to ensure the local system lives within its means, no organisation will take actions that will adversely affect the system financial position, even if it improves their institutional position. Regional oversight will ensure that this does not happen.

The plan includes a commitment that primary medical and community budgets will grow faster than the rest of the NHS

Financial recovery plans

ICSs and STPs will be central in the formation of financial recovery plans (see page 23). ICSs are due to cover the whole of England by April 2021, at which time most providers and commissioners are expected to be back in financial balance. The plan is clear that ICSs must be built on 'strong and effective providers and commissioners, underpinned by clear accountabilities'.

Reforms of funding flows and contracts will support ICS development in 2019 and beyond. Local alliance contracts or arrangements giving a lead provider responsibility for integrating services for a population could be used to support the move towards ICSs.

A new integrated care provider contract is also due to be introduced in 2019 following consultation. This will allow, for the first time, the contractual integration of primary medical services with other services, leading to greater integration. The overall degree of integration will be measured with a new index, which will provide the views of patients, carers and the voluntary sector on how well an ICS is providing joined-up, personalised and anticipatory care.

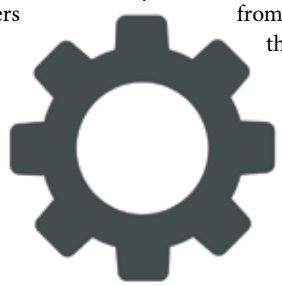
ICSs will have the prospect of earned autonomy. They will agree and implement system-wide objectives with their regional NHS England/NHS Improvement team. The objectives will include integration, improvements in financial and operational performance and priorities for care quality and outcomes. They will have the opportunity to earn greater freedoms as they meet – and improve on – their objectives.

One of the key means of delivering greater integration in the forward view – the better care fund (BCF) – is being reviewed. This follows concerns that the mechanism is overly complex and complaints that funding was replacing core council spending.

There is no hint in the long-term plan that the BCF will be scrapped – instead, it says that the review will be completed early this year and in 2019/20 the revised BCF will continue to require reductions in delayed transfers and the improvement in care packages for patients ready to leave hospital.

Most of the changes to promote integration have been achieved so far without legislation and the plan says no further legislation is needed to achieve the integrated system it outlines. But, in response to a request from the Commons Health and Social Care Committee and the prime minister, the plan outlines a number of legislative changes that could speed up integration. Some of the legal changes would repeal measures in the *Health and Social Care Act 2012*. Legislative changes in the long-term plan include:

- Giving CCGs and providers a statutory duty to promote



current vacancies and with doctors' trade union the BMA claiming that six out of 10 consultants are intending to retire before or at the age of 60, this can only be seen as a partial response to medical shortages. The plan says that medical school places could grow further if Health Education England's budget – due to be set in the spending review – allows it.

The plan also sets an aspiration to develop a better balance between highly specialised roles and more generalist ones – in part as doctors increasingly need to be able to manage multiple comorbidities alongside single conditions. It reiterates plans to boost the GP workforce by 5,000.

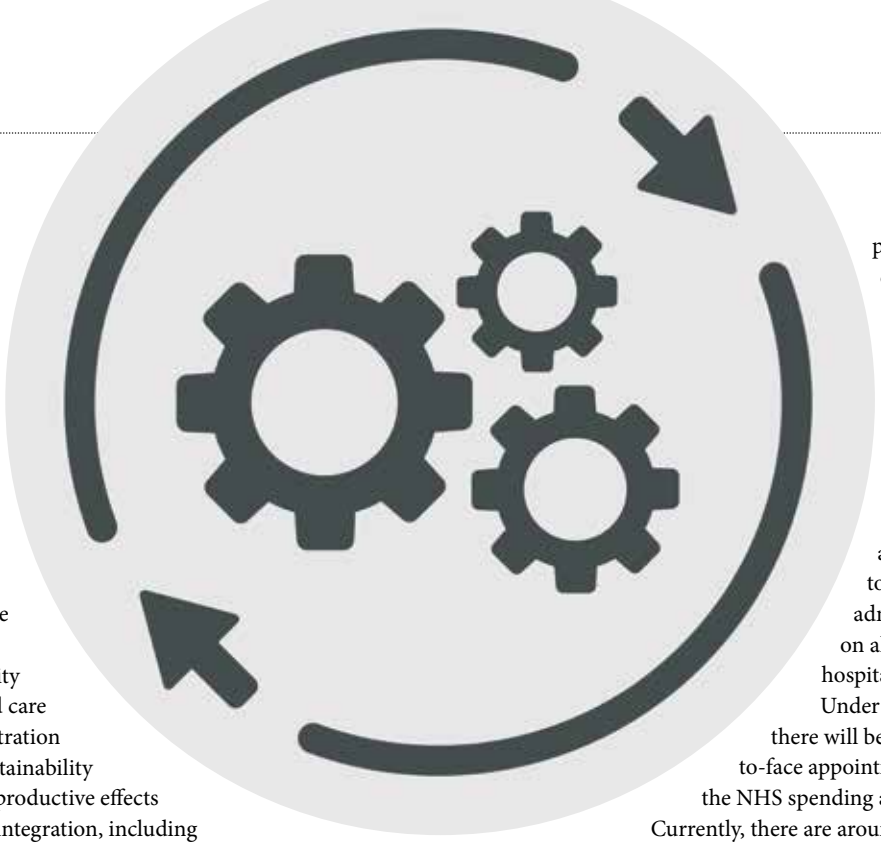
It claims that recruitment has been increasing, but this is being offset by early retirements and part-time working. There will also be a continued push to increase the multidisciplinary teams working in primary care – partly funded through new primary care networks – to relieve pressure on GPs. A step change in the recruitment of international nurses over the next five years is also promised, to increase supplies by 'several thousand each year'.

Retention is equally important to staff expansion plans – arguably more important in early years. The plan promises more development opportunities and more flexibility in working patterns. The plan also recognises that the NHS needs to make the most of the staff it has and signals a renewed effort in getting NHS providers to deploy electronic rosters or e-job plans.

Workforce issues are key to delivering the long-term plan, but while the plan makes the right noises about expanding capacity and growing the workforce, the BMA criticises it for offering little detail. 'Given that there are 100,000 staff vacancies within the NHS, the long-term sustainability of the NHS requires a robust workforce plan that addresses the reality of the staffing crisis across primary, secondary and community care,' says BMA council chair Chaand Nagpaul. 'This will require additional resources for training, funding for which has not been mentioned in the long-term plan.'

And the Royal College of Nursing is similarly concerned by the lack of detail – particularly around money for nurses to develop specialisms in areas such as cancer and mental health.

• An HFMA summary of the long-term plan is available at www.hfma.org.uk



the triple aim of better health, better care and sustainability
- Removing barriers to place-based commissioning and public health collaboration
- Supporting the effective running of ICSs by allowing trusts and CCGs to make decisions jointly without needing to create additional bureaucracy
- Allowing greater flexibility when creating integrated care trusts to reduce administration costs and aid clinical sustainability
- Eliminating the counterproductive effects of competition rules on integration, including the Competition and Markets Authority duty to intervene in proposed NHS provider mergers, and its powers on NHS pricing and provider licence condition decisions
- Cutting delays and costs associated with commissioners automatically having to go through procurement processes
- Increasing flexibility in NHS prices to support the move away from activity-based tariffs, facilitate better integration of care and make it easier to commission some public health services as part of a bundle of care.

NHS England chief executive Simon Stevens says three truths were evident as the NHS celebrated its 70th anniversary last year. First, there was concern about funding, staffing, increasing inequalities and pressures from a growing and ageing population. However, second, there was legitimate cause for optimism – about the potential for continuing advances in medicine and outcomes for patients. And, third, there was pride in the service.

'In looking ahead to the health service's 80th birthday, this *NHS long-term plan* acts on all three of these realities. It keeps all that's good about our health service and its place in our national life. It tackles head-on the pressures our staff face. And it sets a practical, costed, phased route map for the NHS's priorities for care quality and outcomes improvement for the decade ahead,' he adds.

King's Fund chief executive Richard Murray backs the development of ICSs. 'We strongly support the ambition to establish integrated care systems in every part of the country by 2021,' he says. 'The plan sends a welcome signal that NHS organisations need to work with local authorities and other partners to deliver improvements in the health of local populations.'

Primary and community focus

As previously highlighted, the plan includes a commitment that primary medical and community budgets will grow faster than the rest of the NHS, with a ringfenced fund of at least an extra £4.5bn a year in real terms by 2023/24.

The focus on community and primary care is welcomed by Matthew Winn, chair of the NHS Confederation community network. General practice, community and social services will work together in expanded community multidisciplinary teams, with primary care networks across GP practices taking on enhanced service activities.

'It is extremely positive that community services, working in partnership with primary care, will play a central role in supporting a sustainable NHS for the long-term future,' he says. 'A shift in focus towards prevention and community care will help ensure people can live healthier, longer lives, and receive care in or close to their homes, reducing admissions and demand on already over-stretched hospitals.'

Under the new service model, there will be a move to reduce face-to-face appointments in a bid to avoid the NHS spending an extra £1bn a year. Currently, there are around 400 million of these appointments a year and under the scheme every patient will have a right to an online consultation with a GP, while redesigned support will avoid up to a third of hospital outpatient appointments (around 30 million each year).

Mental health

Mental health will also have ringfenced funding, with a new local investment fund worth at least £2.3bn a year by 2023/24. The funding will target service expansion and faster access to community and crisis mental health services for adults and, in particular, children and young people.

Centre for Mental Health chief executive Sarah Hughes says the plan is right to extend mental health services and improve response times. She adds: 'If they are properly funded and resolutely implemented with a robust workforce development plan, they will make a big difference. However, this plan on its own falls short of offering a comprehensive shift towards equality for mental health within the NHS.

'It says little about the role of primary care in mental health, despite the growing gap in services for people with a range of needs that fall between existing services. And there is scant focus on seeking to address longstanding inequalities in mental health despite the clear evidence about differences in access, experience and outcomes for many of the most disadvantaged and marginalised groups in society.'

New urgent care services, which will be rolled out across all acute hospitals, will relieve pressure on emergency departments and inpatient beds. Longer-term action will also be taken to stem demand with a focus on ill-health prevention. The plan insists this is complementary to – not instead of – individuals, communities, government and companies taking responsibility for shaping the nation's health.

Evidence-based prevention programmes will be funded. For example, as trailed in *Healthcare Finance* (*December 2018, Stubbing it out*), there will be a new hospital-based smoking cessation service. Other programmes aim to tackle obesity, alcohol-related A&E admissions and air pollution.

The long-term plan was eagerly anticipated and has been widely welcomed. Even so, there are questions over the detail of how it will be implemented – will the extra funding be enough to expand and transform services while bridging the gap in NHS finances; will workforce issues finally be addressed; and can years of competition be overcome to produce collaborative, sustainable ICSs?

Recovery route

The long-term plan and planning guidance have set a trajectory towards financial balance, as Seamus Ward reports

The NHS long-term plan aims to have a near immediate effect on provider finances, reducing those reporting deficits by more than 50% in the first year.

The plan insists that no trust or clinical commissioning group should have a deficit by 2023/24 and there will be a multi-pronged approach to reducing deficits. These include:

- Targeting deficits thought a financial recovery fund (FRF)
- Boosting trusts' potential income by transferring £1bn of the provider sustainability fund (PSF) to the urgent and emergency care tariff – some CQUIN funding (1.25%) will also be transferred into local and national tariffs
- Introducing an accelerated turnaround process for the 30 trusts with the worst financial performance – details are scant, but the plan says these trusts account for the net total of the provider deficit
- Increasing productivity and efficiency.

The £1.05bn FRF is expected to make the biggest immediate impact. In 2019/20, the total will include £200m transferred from the PSF. Payments will be non-recurrent and, in 2019/20, only deficit trusts that have signed up to their control total will be eligible. All trusts in receipt of the funds must produce a multi-year recovery plan during 2019/20, which should be in place from December this year as part of their five-year system-level strategic plans.

From 2020/21 the fund will be restricted to trusts in deficit with a financial recovery plan that has been agreed with the appropriate NHS England and NHS Improvement regional team. Funding released by over-delivery against the recovery plan will, where possible, be redeployed in transformation and cost reduction.

As the number of deficit trusts falls, more of the PSF will be transferred into the financial recovery fund.

The tariff uplift for 2019/20 will be 3.8%, subject to consultation. This includes funding for the Agenda for Change pay rises, but excludes the transfer of £1bn of PSF into urgent and emergency care prices, the CQUIN transfer and funding (£1.25bn per year) for an increase in employer pension contributions.

The transfers out of the PSF mean that in 2019/20 the value of the fund will be reduced from £2.45bn to £1.25bn. A further £155m will be transferred to the non-acute sector and the remaining £1.1bn in the PSF will be allocated to acute and specialist trusts using the same methodology as in 2018/19.

The tariff efficiency factor will be 1.1%, but all trusts with a deficit control total will be required to deliver additional efficiencies of 0.5% – trusts will retain this to support their financial recovery.

According to the long-term plan, the majority of trust leaders (52%) believe that opportunities for greater efficiency remain. Clinically-led improvement programmes, including *Getting it right first time*, NHS RightCare and Quality Improvement, will accelerate the removal of unwarranted variation.

In the next two years, the health service will focus on 10 areas to strengthen its efficiency and productivity programme. These areas include: improving the deployment of clinicians, further reducing bank and agency costs; continuing aggregating and standardising procurement, with 80% of NHS supplies bought through Supply Chain Co-ordination Ltd by 2022; introducing pathology and imaging networks; increasing efficiency in primary, mental health and community services; and saving £700m in admin costs by 2023/24 (£290m from commissioners and more than £400m from providers). The savings will be achieved by reducing bureaucracy and automating all core transactional services, including invoice payment processing.

The plan says that over the course of the next five years recurrent efficiency improvements should mean the level of funding in the FRF can be reduced.

NHS Providers chief executive Chris Hopson (pictured) says the planning guidance and the long-term plan help trusts see how they can begin to recover performance, address workforce shortages and move back towards financial balance in 2019/20. 'The provider sector will welcome the overall new financial regime set out in the guidance,' he says, '[including] the extra investment in the sector, the increase in prices paid to trusts for the care they provide, the new provider financial recovery fund, the changes to funding emergency care and a more realistic efficiency assumption than before of 1.1%.

'Trusts will want to assess the impact of a complex set of changes on their individual position, recognising that each trust has an important contribution to make to returning the sector to financial balance. But, taken as a whole, this should enable the provider sector to start moving from deficit to surplus, an important and significant achievement.'

HFMA Qualifications
Qualifications in healthcare business and finance

hfma

Discover our postgraduate modules

- Making finance work in the NHS
- Managing the healthcare business
- Personal effectiveness and leadership
- Tools to support decision-making in healthcare
- Creating and delivering value in UK healthcare
- Comparative healthcare systems
- Supporting quality care through patient-level costing

Contact HFMA to find out more:

hfma.to/level7
0117 938 8315
qualification.enquiry@hfma.org.uk

hfma
professional lives
Events, people and support for finance practitioners

Finance staff alerted to reporting changes in 2018/19 finance manuals

Technical

December is traditionally the month in which the Department of Health and Social Care and the Treasury release their respective finance manuals, and 2018 was no different, *writes Debbie Paterson*. The DHSC published the first frequently asked questions that amend the *2018/19 Group accounting manual* (GAM). The Treasury published revisions to its *2018/19 Financial reporting manual* (FReM), as well as the *2019/20 FReM*.

For 2018/19, some of the changes will have more of an impact than others. In the 'less impact' column are FAQs 2, 3 and parts of 5. FAQ 2 provides the annual update to the probability of non-recovery of income from the injury costs recovery scheme. FAQ 3 simply makes minor updates to wording and terminology in the GAM – these add clarity but make no changes. Parts of FAQ 5 should also cause little concern (see below).

The areas requiring more attention include FAQ 1, 4 and the other parts of 5. FAQ 1 sets out discount rates at 31 March 2019. This is usually a straightforward annual update but, this year, there has been a change in methodology for discount rates with nominal rates now being applied rather than real rates. The FAQ sets out the different nominal and inflation rates that NHS bodies use for their various provisions and financial instruments.

FAQ 4 will be important for providers of maternity care as it sets out how the maternity incentive scheme with NHS Resolution should be accounted for. The maternity incentive scheme is not accounted for under IFRS 15 *Revenue from contracts with customers*. Instead amounts received from the incentive fund are offset against contributions to the Clinical Negligence Scheme for Trusts.

Any award from the incentive scheme is only recognised when NHS Resolution has confirmed the amount payable to the trust.

SHUTTERSTOCK

FAQ 5 takes the Treasury changes to the FReM and applies them to the GAM. The changes include:

- Take account of the IASB's *Conceptual framework for financial reporting*
- Introduce a link to the employer pension notices produced by the Cabinet Office
- Clarify that all public sector bodies should apply IFRS 8 *Segmental reporting* in full
- Refer to the new *Contingent liability approval framework* published by the Cabinet Office
- Reflect the language used in the UK *Corporate governance code* in relation to the annual report and accounts being fair, balanced and understandable in the statement of accounting officer's responsibility.

The following three issues may need more attention:

- Replace references to the *Data Protection Act 1998* with the *Data Protection Act 2018*: this amendment introduces new requirements to engage with senior managers in relation to their remuneration disclosures
- Reflect the requirements of the *Trade Union (Facility Time Publication Requirements) Regulations 2017* (if not done already)
- Highlight further adaptation of IFRS 15:
  - To the definition of a contract in the public sector to ensure consistency with IAS 32
  - To provide additional detail in relation to revenue from fines, taxation and penalties, for NHS bodies. This has the practical impact of bringing injury cost recovery receivables into the scope of IAS 32 and therefore the financial instrument disclosures.

In addition to the manuals, the quarter 4 agreement of balances timetable and guidance has been published with no major changes. The NHS Business Services Authority has published its *Greenbury guidance*, which sets out how requests for senior manager pension information should be submitted and the timeframe to make those requests – between 7 January and 28 February 2019.

The supporting guidance and examples have been comprehensively reviewed and updated. So it is worth even the most hardened veteran revisiting it.

Looking further ahead, the Treasury has also published the *2019/20 FReM*. The main change is that this FReM includes guidance on IFRS 16 *Leases* to allow for early adoption by those public sector companies that have to meet the requirements of the *Companies Act 2006* and EU-adopted IFRS.

While NHS bodies will continue to apply IAS 17 in 2019/20, the IFRS 16 parts of the FReM and application guidance are worth looking at as they specify how the standard will be interpreted and amended for public sector bodies.

Debbie Paterson is HFMA policy and technical manager

Qualification demonstrates its broad appeal

Alison Myles, HFMA director of education
News and views from the HFMA Academy

Training

We held our second graduation ceremony in December at the HFMA annual conference. It was a great occasion and our successful students said they thoroughly enjoyed it too. But more than anything, the ceremony marked a key milestone in what is fast becoming an established and well-regarded postgraduate qualification in healthcare finance.

Developing this qualification has been a longstanding ambition for the HFMA. Student feedback is that it is demanding, but hugely rewarding. And the enthusiasm of students and ongoing interest in new sign-ups to different aspects of the qualifications confirms that we are meeting a specific demand in the area of healthcare business and finance.

Forty-one graduates were invited to the ceremony, including students who had completed either of the two diplomas (advanced or advanced higher), as well as students receiving their advanced certificates for completing the core *Making finance work in the NHS* module. This module is mandatory as part of the advanced diploma, but can also be studied separately as a standalone course (as can other modules in both diplomas). In total, more than 100 people have studied for some aspect of these level 7 qualifications during the past year.

Reading the job titles and organisations of our successful students gives a real insight into the broad appeal of this qualification, both inside and outside the finance function. We had people from across the whole spectrum of NHS finance, from chief finance officers to directorate accountants and finance business partners – from commissioners, providers and national bodies. There were representatives from planning and contract governance. And the clinical community was also well represented with specialty registrars, clinical fellows and associate medical directors. There was even a commercial banker.

Given this spectrum, it is no wonder students value the networks created by the cohort of students, giving everyone the opportunity to see things from different perspectives.

Seven of the students successfully completing the advanced higher diploma are embarking on the final third of a new MBA programme in healthcare finance, developed by BPP University – which kicks off in February. That's another exciting development, and we are sure there will be lots more to follow.

The awards ceremony also saw Sonita Osborne, head of financial services at George Eliot NHS Trust, named as the winner of the 2018 Tony Whitfield Award, recognising her as the student of the year.

The award, which was being presented for the second time after last year's launch, was named after former HFMA president Mr Whitfield, who was a major contributor to the association's education agenda. Mr Whitfield sadly died over the Christmas period (see page 30).

Although he was too ill to attend December's ceremony, he sent a message underlining how the qualification was in keeping with his theme while president – *Knowing the business*. The theme was based on a belief that to serve patients and taxpayers you need an understanding of the context of healthcare. 'It is incumbent on us to ensure we undertake continuing professional development to keep [our] knowledge base fresh,' he said. 'In taking a course of study with the HFMA, you are embodying that belief – a rigorous endeavour tailored to our industry.'

Ms Osborne, who completed the advanced higher diploma, was selected from a shortlist of three students, which included Carl Smith (Leeds West Clinical Commissioning Group) and Gianluca Paderi (Nottingham University Hospitals NHS Trust). Ms Osborne's award was collected on the night on her behalf by Haq Khan, director of finance at George Eliot.

Value takes centre stage

Future focused finance

Significant change is on the horizon for healthcare, from the way that we work as a system, to the technology we use and what patients expect from the NHS.

The NHS continues to show unparalleled resilience in the face of mounting pressure, but it is widely agreed that the current climate is unsustainable. How do we close the gap between demand and resource to create a truly sustainable healthcare system?

One way to do so is to build collaborative relationships between financial and clinical teams to ensure that quality, measured by outcomes and cost, is considered when making value-based decisions.

Future-Focused Finance and the HFMA's Healthcare Costing for Value Institute have teamed up for the Value summit 2019. This event, to be held on 22 May, will tackle this key piece in the value jigsaw – clinical and financial collaboration. The day will provide real-life examples of clinical and financial teams working together to close the gap between demand and resource, helping to create a truly sustainable healthcare system.

As the focus of the day will be on clinical-financial collaboration, we hope to get a 50/50 split of finance and clinical delegates.

Speakers include: Sir Muir Gray, executive director, Oxford Centre for Triple Value Healthcare; Jane Carlile (pictured), group medical director and consultant psychiatrist, Northumberland, Tyne and Wear NHS Foundation Trust; Bill Gregory, HFMA president and Lancashire Care NHS Foundation Trust chief finance officer; and Jagtar Singh, Coventry and Warwickshire Partnership NHS Trust chair.

• **To book your place, please email** futurefocusedfinance@nhs.net

Diary

February
7 (N) HFMA/CIPFA integration summit, Rochester Row
11-12 (N) Chief executive forum and dinner
13 (F) Mental Health Finance: technical forum, Rochester Row (am)
13 (F) Provider Finance: technical forum, Rochester Row (pm)
27 (I) Institute: value masterclass

March
1 (B) Eastern: accounting standards and VAT update, Fulbourn
14 (N) Brighter together: leadership masterclass, Rochester Row

April
10 (I) Institute: costing conference

May
9 (B) South Central and South-West: developing talent (with SDN), Reading
15 (F) Provider Finance: forum, Rochester Row (am)
15 (F) Mental Health Finance: forum, Rochester Row (pm)
16 (F) Chair, Non-executive Director and Lay Member: forum
22 (F) Commissioning Finance: forum

June
13 (B) West Midlands: annual conference, Birmingham
21 (B) Northern: Keep stepping, Durham

July
4-5 (N) HFMA summer conference, Bristol

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

key (B) Branch (N) National (F) Faculty (I) Institute

Webinar archive

As well as developing new webinars, the HFMA has made available a raft of recorded online seminars, including the hugely popular IFRS16 *Leases*.The webinars on offer are free and go back to 2012, although you must be an individual HFMA member to view webinars recorded after 1 September 2016. Some prior to this are also available to affiliates.

The IFRS16 webinar has been watched more than 1,200 times. Led by HFMA policy and technical manager Debbie Paterson, it includes a high-level summary of the requirements of IFRS16; a look at its impact on the NHS; and a discussion of NHS-specific issues identified so far.

Other webinars available include an explanation of HMRC's *Making tax digital* programme and an exploration of how to realise recurrent savings and other benefits with digital healthcare.

• For the IFRS 16 webinar and other recorded seminars, go to www.hfma.org.uk/education-events and click the *On-demand* webinars tab

Events in focus

Integration summit: sharing learning from across the devolved nations
7 February, Rochester Row, London

The fourth annual integration summit is designed to bring together a wide range of stakeholders, from local authority treasurers to NHS provider finance directors, directors of adult social services, integration authorities, commissioner chief finance officers and system leaders.

With the *NHS long-term plan* putting integration at the top of the agenda in England, the summit will hear the experiences of the devolved nations – despite their individual structural designs and local challenges, broadly speaking, they face many similar issues.

This event, jointly organised by the HFMA and CIPFA, seeks to share the learning from all four nations. The summit will also examine the *NHS long-term plan* for England and hear views on the impact of the government green paper on social care. Speakers from the devolved nations will include Steve Elliot, Welsh government deputy director of finance for health and social services, Neil Guckian (pictured), director of finance and estates at the South Eastern Health and Social Care Trust and John Jackson, director of adult social services at Oxfordshire County Council between 2007 and 2016.

• For further details or to book a place, email josie.baskerville@hfma.org.uk

HFMA summer conference
4 July, Bristol Ashton Gate stadium

The association's annual summer conference brings together its commissioning and provider finance network conferences and is now in its 15th year. The integrated nature of the conference reflects the move to system working in the NHS and the event will focus on integration, ill-health prevention and the use of technology in the health service.

Delegates include senior finance professionals from acute, community and mental health providers, and commissioning organisations, as well as those from arm's length bodies.

Speakers include Tim Kendall (pictured), national clinical director of mental health at NHS Improvement, and Public Health England finance and commercial director Michael Brodie.

Members of the HFMA partner programme can receive discounted rates for this event.

• To book your place at the conference, please contact josie.baskerville@hfma.org.uk

Leading the way

Association view from Mark Knight, HFMA chief executive

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

SHUTTERSTOCK

My HFMA

The untimely passing of our former president Tony Whitfield is an absolute tragedy, not only and most obviously for his family, but also for the HFMA. His enthusiasm and energy for our agenda was unrivalled. At 61, he leaves us at a relatively young age, but he has left his mark indelibly on us. I, for one, will never forget him.

Tony was, in a sense, similar to many of us 'working class boys and girls' (to use one of his phrases). From a solidly working class background, his first big break was passing the 11 plus and attending Altrincham Grammar School – a big deal in those days. My uncle did a similar thing in Birmingham and my grandmother had to go back to work just to pay for the uniform and other 'essentials'.

Tony's life was full of examples of him taking opportunities, first to qualify as an accountant then to be a director of finance. He led the finance teams at three trusts in his NHS career and became president of his professional body and an OBE to boot!

But the bare facts of Tony's career don't sum him up. Tony's energy and creativity meant he became a national NHS treasure, a go-to person, always there to be consulted. At the very end of his life, before Christmas, I travelled to the hospice in Warrington to see him. I spent a wonderful three hours there. He was keen to learn about the annual conference, which he had missed for the first time since becoming a finance director. He was annoyed that a back injury had prevented him from hearing Bill Gregory's speech, as he had encouraged him to get involved in HFMA many years before.

I told Tony about the opening panel session, when René Carayol interviewed three prominent role models on the wider subject of diversity. I talked about the concept of 'imposter syndrome', about which NHS Improvement's Elizabeth O'Mahony spoke so elegantly. That's where, in the middle of doing something, you suddenly ask: how did I get in this job and is this really

HFMA chief executive Mark Knight

me? I certainly recognised this feeling and Tony did too. We agreed it was the result of being brought up with expectations low.

Our new president's theme of *Value the opportunity* hits this nail firmly on the head. Many of us will not have had a ready packaged career laid out ahead of us. However, the system – through work and our association – offers us opportunities we must take. And it is by grabbing hold of these chances and pushing hard into them that we can achieve real success.

The aspiring finance directors programme, run by FFF, has provided opportunities for our future finance leaders. And our excellent suite of qualifications and other professional development opportunities are also helping people become the best they can be.

As a member of our Quality Assurance Committee, Tony argued strongly for the HFMA to enter the qualifications arena. Hard work took him from being a working class boy in Warrington to one of the most respected finance directors in the NHS. We should all follow in his footsteps and value the opportunity.

Member news

A number of announcements were made at December's annual general meeting regarding senior HFMA roles:

- Bill Gregory was elected president for 2018/19.
- Sue Jacques, Keely Firth and Huw Thomas ended their terms as trustees.
- Lee Bond, Rachel Hardy, Claire Wilson, Sandra Easton and Alun Lloyd were appointed to the board of trustees.
- Caroline Clarke was named vice president for her second year, and Owen Harkin vice president for his first year.

In addition, several faculty and committee chairs were named:

- Robert Forster, Provider Technical Issues Group
- Ian Moston, Policy and Research Committee
- Ken Godber, Charitable Funds Special Interest Group
- Duncan Orme, Research and Development Costing Group
- Suzanne Robinson, Mental Health Faculty/Steering Group
- Ros Preen, Healthcare in the Community Special Interest Group
- Anthony Robson, VAT sub-committee
- Karl Simkins, System Finance Lead Group
- Su Rollason, Healthcare Costing for Value Institute Council

Colin Murray (pictured second right) of the Business Services Organisation was awarded the annual Fred

Armstrong award at the HFMA Northern Ireland Christmas Cracker event. The award goes to an individual or group that has showed professionalism, initiative, problem-solving and communication skills and development potential during the year. Fred Armstrong, who died in 2004, worked in the Northern Ireland Health and Personal Social Services for 28 years, across all areas of the finance function and left a lasting legacy among his colleagues.

hfma

Member benefits

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

Branch focus

My HFMA

North West Branch

The past four winners of the HFMA Finance Director of the Year Award have all been from the North West Branch. And this year, local organisations bagged four of the eight national awards.

In 2016, Bolton Clinical Commissioning Group and Bolton NHS Foundation Trust won the Innovation Award for their aligned incentives contract – where the commissioner and provider work together to deliver services and ensure they achieve their planned financial position.

'Some early successes, when the awards became as big and important as they are for the industry now, really caught the imagination and inspired a lot of organisations in the North West. It's a great way of showcasing local innovation,' says Ian Boyle (pictured), director of finance at Bolton Clinical Commissioning Group and chair of the branch – who had himself won a Student of the Year Award in 1998.

'The organisations from the North West are so successful in the national awards because they're open to new learning and new ideas. The good efforts of local finance teams have consistently produced excellent work and candidates for those awards.'

To support innovation in the patch, the branch holds regular events and an outstanding annual conference. The latest HFMA award winners will present their successful initiatives at this year's branch conference on 27-28 June at the Grand Hotel, Blackpool.

'Our role is to make sure everyone in the North West is looking for innovative ideas and keeps driving improvement,' says Mr Boyle.

The branch is also preparing events to support its members with the recently published planning guidance and long-term plan.

Mr Boyle's organisation is in one of the localities in the Greater Manchester devolution area. His CCG is currently looking at what the 10-year plan would mean for its locality plan. 'We have already achieved some of the recommendations of the plan,' he says. 'But there is still work to be done in other areas and this is why these events will be very helpful.'

• Find out more about the branch at **hfma.to/northwest** and follow it on Twitter **@HFMANW**. The branch will welcome members from other regions at its conference.

branch contacts

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex stuartwayment@nhs.net
London katie.fenlon@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern catherine.grant2@nhs.net
North West hazel.mclellan@hfma.org.uk
Scotland alasdair.pinkerton@nhs.net
South West laura.ffrench@hfma.org.uk
South Central katie.fenlon@hfma.org.uk
Wales georgia.purnell@hfma.org.uk
West Midlands fleur.sylvester@hfma.org.uk
Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

Huw Thomas (pictured) has been appointed director of finance at Hywel Dda University Health Board. He joined the organisation in April last year as deputy director of finance and became interim director of finance in September. A chartered accountant, he worked in private practice before moving to the NHS, first in England and, latterly, Wales.

The Royal Free NHS Foundation Trust has appointed **Lisa Marsh** director of operational finance. Ms Marsh has over 10 years' experience in senior finance roles in the NHS.

Andy Ray (pictured) is now chief finance officer at Mid and South Essex Joint Commissioning Team. He is on secondment from his post as director of financial operations at Barking, Havering and Redbridge University Hospitals NHS Trust. Mr Ray is returning to the South Essex health economy, where he's worked for 25 years, most recently as deputy director of finance at Basildon and Thurrock University Hospitals NHS Foundation Trust. He also chairs the HFMA Eastern Branch.

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust has appointed **Zoe Plant** head of contracting and costing. Her previous role was as deputy director of contracting at Lincolnshire Community Health Services NHS Trust, and she has more than 25 years' experience in healthcare finance.

Following his participation in the NHS aspiring finance leaders programme, **James Thomson** has been appointed director of finance at The Clatterbridge Cancer Centre NHS Foundation Trust. He was previously deputy director of finance at The Christie NHS Foundation Trust, and has experience working in a range of NHS organisations in senior roles. These include regional head of finance at NHS Property Services and deputy director of finance at East Cheshire NHS Trust. He is taking over from acting director of finance **John Andrews** and will be succeeded as deputy director of finance at The Christie by **Kate Whiting**.

NHS England and NHS Improvement have confirmed their joint directors. **Julian Kelly** will take up the position of NHS chief financial officer in April. He is currently director general nuclear, leading the Defence Nuclear Organisation at the Ministry of Defence. NHS Improvement chief financial officer **Elizabeth O'Mahony** (pictured) has been named regional director for the South West. NHS England chief finance officer **Paul Baumann** stepped down in the autumn.

obituary

Tony Whitfield

Tony Whitfield OBE passed away on Christmas Eve aged 61. He died peacefully in Warrington, the town he was born and brought up in, and where he lived all his life.

Tony was an inspiration to many working in the NHS and was influential, both across the local health economies in which he worked and at a national level.

He joined the NHS in 1983 after seven years in finance roles in manufacturing and services, including Rylands wire factory and North West Water. Initially, he joined what would become St Helens and Knowsley Hospitals NHS Trust. He held several finance posts and began working with clinical and non-clinical staff to improve service efficiency and effectiveness.

It was 1992 when he became director of finance and deputy chief executive of the trust. In this role, he oversaw a successful clinical rationalisation and approval of the business case for the new Whiston and St Helens hospitals, procured through the private finance initiative bid. In 2002, he also had a spell as the trust's acting chief executive.

He moved to Salford Royal NHS Trust in 2003, where he was deputy chief executive and finance director until the end of 2013. During his time at Salford, he delivered strong financial performance, based on service line management and patient-level costing – initiatives he passionately pioneered.

He was responsible for the financial plan that underpinned the trust's successful foundation trust application alongside a full business case for the PFI-rebuilding of Salford Royal.

He continued to engage closely with clinicians. This included an award-winning project in which he worked with two neurologists to develop a strategy to reduce inappropriate demand for their service and developing partnerships with other trusts to provide clinical and clinical support services. He led the trust's bid to provide hyper-acute stroke services in Greater Manchester, based on a collaborative model recognised as having some of the best outcomes in the country.

In early 2014, he moved to become finance director at The Leeds Teaching Hospitals NHS Trust, a post he occupied until his retirement on ill health grounds in 2017.

At Leeds, he restructured the finance team and oversaw an improvement in the previously poor financial position. Before passing away, he talked at length about his work in transforming Leeds and reflected with some pleasure on the trust winning the HFMA Finance Team of the Year Award in 2018.

In 2009, Tony joined the HFMA Board as a trustee, a post he occupied for nine years, stepping down in December 2018, having served his full term as a trustee. He championed patient-level costing and led the association's work to develop clinical costing standards on behalf of the Department of Health, which provided a foundation for NHS Improvement's Costing Transformation Programme.

Tributes

Sue Lorimer, non-executive director, Wirral University Teaching Hospitals NHS Foundation Trust, and HFMA president 2015

'I met Tony 25 years ago when I returned to Liverpool from Norfolk and since then he never failed to make me laugh with his wry humour and his unique take on the world. Although not one to suffer fools gladly, Tony genuinely cared about his colleagues and was always keen to reach out to provide support.

'There will be many people reading this who have had a call or a text from Tony when they were at a low point in their careers.

'He has left a lasting legacy to the world of NHS finance and that gained him an OBE. But I like to remember him more as the bloke who would ring me up randomly to talk about an old episode of *Crossroads* or *The Sweeney* or some other 1970s' programme he'd found on television or the internet.

Tony will be remembered for his mantra that NHS finance staff should "know the business". For Tony it was more than that and the interest he showed and the effort he put into his HFMA and finance director work demonstrated that he was not only somebody who knew the business but loved it too.'

Jane Tomkinson OBE, chief executive, Liverpool Heart and Chest Hospital NHS Foundation Trust

'I met Tony 20 years ago when I moved to the North West. Our first encounter was at the strategic health authority finance directors forum, where Tony spotted a new and very green deputy who clearly knew no-one and nothing.

'Even 20 years ago Tony was regarded as an "elder statesman" but he came over, introduced himself and explained who everyone was.

'This made me feel so much more at ease. Tony subsequently continued this support and mentorship, always providing sound advice, and the odd "get a grip" when needed!

'Tony was a true gent who had time for everyone, a very dry sense of humour and a source of long and entertaining stories of the farm in Ireland. I will miss my friend, colleague and adviser.'

In 2012/13, Tony served as president of the HFMA, overseeing the opening of 110 Rochester Row – the HFMA's London base and conference centre. He was closely involved with national work to understand the implications of seven-day services for emergency and urgent care and led the HFMA's costing work in this area – paving the way for the subsequent establishment of the HFMA Healthcare Costing for Value Institute.

His president's theme of *Knowing the business* struck a chord with members and contributed to a much greater focus on clinicians and finance working more closely together. He was also instrumental in the early work to develop new qualifications at the HFMA – a fact that was recognised with the establishment in 2017 of the annual Tony Whitfield Award for the association's qualifications programme student of the year. In the new year's honours list of 2017, Tony was made an Officer of the Order of the British Empire for his service to the NHS.

The bare facts don't really do Tony justice – he had a hugely influential career in the NHS at the organisation, regional and national level. But he amounted to a lot more than that. He was inspirational, regarded by many as a true leader of the profession.

He recognised the importance of having a strong and highly skilled finance team and was loyal to his staff and very inclusive, drawing on his personal experiences with stories for any and every situation.

Those who worked with him cited him as the person who pushed them on one step further, with an incredible vision and energy.

Tony was known as someone who empowered his staff and transformed the fortunes of three NHS organisations. At the HFMA, his ambition was the same, becoming very involved nationally in 2007 with the creation of the HFMA's (then new) foundation trust faculty. By late 2012, he was president. Tony was inspiring but challenging, and he knew what he wanted the association to achieve. He was passionate about the HFMA and wasn't frightened to tell you! You always knew where you were with him and he preferred to tell you face-to-face.

But above all, Tony was a kind man, always upbeat, friendly and enthusiastic, and with a dry sense of humour. He thought of others and he cared about his fellow human beings. He was always sensitive to others and amused by people in general.

He is survived by his wife Janet and two children, Phillip and Fiona.

Tributes

Bill Gregory, chief finance officer and deputy chief executive, Lancashire Care NHS Foundation Trust, and current HFMA president

'I first met Tony when I took up my first director of finance post at Liverpool Heart and Chest. Tony was then director of finance at St Helens and Knowsley. During this time I remember my first insight to Tony's view on the world, and in particular human behaviour, when he likened the Mersey acute director of finance meeting to the famous Monty Python four Yorkshire men sketch, when they started comparing the size of their financial problems. He was never short of sharing his views on life, but was always ready to listen to yours too, especially if you had a few problems of your own.

'Our paths crossed again when we both worked in the Greater Manchester system. When I took up my post in Stockport, he made a point of calling me to congratulate me on my appointment and to make sure I knew where to find him if I needed a chat. This is something I know he did for many people, not only making a personal contact, but helping make you feel part of the health system.

'Tony may have left us now, but his influence very much lives on. That might be in the ideas and plans people have made as a result of something sparked during a "Tony" conversation, working in a team he helped shape, benefiting from care in a hospital he helped create, or in my case that little push to get outside my comfort zone to achieve a bit more.'

Sue Jacques, chief executive, County Durham and Darlington NHS Foundation Trust, and HFMA president 2012

'Tony was a giant in the world of NHS finance and his legacy will live on for decades to come whether through the national initiatives he sponsored and supported such as the Healthcare Costing for Value Institute or the personal advice and words of wisdom that he shared with so many of us. Although he'll be a big loss, his impact has been and will be even greater. From a personal perspective I know I am a better individual for knowing Tony and suspect a lot of colleagues will feel likewise.'

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

"When I go into hospital to talk about transformation, clinicians know I understand them, and we can have a conversation"
Lei Wei, North West London Collaboration of Clinical Commissioning Groups

Wei steps up career with NW London move

On the move

Newham Clinical Commissioning Group interim chief finance officer Lei Wei has been appointed deputy chief finance officer at North West London Collaboration of Clinical Commissioning Groups.

There are eight CCGs in the collaboration, including those covering Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Central London (Westminster). On a day-to-day basis, Ms Wei will focus on Westminster, Kensington and Chelsea, and Hammersmith and Fulham. She will also be supporting the development of the QIPP programme across the eight CCGs, ensuring it links to the local strategy and transformation programme and is consistent with financial plans.

'This is career progression for me,' she says. 'I have been interim CFO at Newham for the past 16 months and have been at the CCG for almost four years. I started as deputy and, when my predecessor retired, the board asked me to step up on an interim basis.

'I've learned a lot supporting the CCG and local STP, and I think it's now the right time to experience different leadership styles and work in other areas of London.'

North West London also offers her a chance to be involved in potentially one of the biggest game-changing developments in services to patients in recent times. Hammersmith and Fulham CCG, together with one local GP practice, has been developing GP video consultations. 'It's a chance to get involved in supporting that, and contributing more to GP digital development. It will be really exciting to be involved in that.'

More widely, Ms Wei is excited to contribute to the management and financial recovery of Central London Clinical Commissioning Group, which is facing significant finance pressures. And, following restructuring, the CCGs have new senior leadership, including Paul Brown, who is CFO at all eight commissioning groups.

Mental health investment – a significant element of the *NHS long-term plan* – will be one of her priorities. 'It's a key area and, in line with the long-term plan, an area where we will need to get a better grip.'

Originally from China, Ms Wei trained in medicine in Beijing. But during her internship, she became interested in the management of resources, adding value and decision-making at system level.

She moved to London and completed a masters in international health management. Then she applied to the NHS graduate management trainee scheme, but ended up at PwC, working with public sector clients. After six years, Ms Wei joined the NHS, as Newham CCG deputy chief finance officer.

'I use both my medical background and finance knowledge – when I go into hospital to talk about transformation, clinicians know I understand them, and we can have a conversation,' she says. 'As a manager, I want to make things easier for patients and frontline staff and having this experience in my past helps to make better decisions, especially with the upcoming challenges and better way of working for the system.'

Ms Wei is part of the cohort of finance staff participating in the NHS aspiring finance leaders network, which was created by the Skills Development Network, the HFMA and Future-Focused Finance to bring forward the next generation of senior finance staff.

'I want to keep participating in events and working with my peers. There are not many of us in London, but as part of the programme we have our own action learning group , which we are finding really useful.'

The network has given her a step up, giving her the confidence to apply for more senior jobs. 'It's created a platform that's allowed me to meet peers from different parts of the country and different NHS sectors, as well as learn from highly experienced finance directors and chief executives,' she adds.

She is also keen to support the health service's programmes to develop greater diversity among senior finance staff. 'We need more women and people from BME backgrounds at senior level to represent the population we are serving, and it requires everyone's efforts to achieve that.'

Download
your member app today

myHFMA

Download on the App Store

GET IT ON Google Play

myHFMA

Delivering up-to-the-minute news, comment, policy and technical information that matters to you.

CareAdvantage | Johnson & Johnson MEDICAL DEVICES COMPANIES

Johnson & Johnson Medical Devices Companies – Helping hospitals reach their full potential

Hospitals are under pressure to do more with less[1]

Growing and aging population means pressure on services[2]

Lifestyle changes are causing increase in chronic diseases

Insufficient funding or cash flow to purchase services and equipment

Perfectly placed to provide tailored financing solutions for hospitals

At Johnson & Johnson Medical Devices Companies, our financing solutions help hospitals grow by overcoming funding challenges, so they can implement different solutions with access to new services, technology and equipment.

Solving starts with listening

Our approach to helping healthcare providers…

We listen to make sure we offer a solution that is right and achievable for each customer.

About CareAdvantage

With CareAdvantage, we work in partnership to co-create tailored solutions that are achievable and measurable.

Proud supporter of HFMA

To find out more, contact:
emeacareadvantage@its.jnj.com

1. Care Quality Commission. The state of health care and adult social care in England 2015/16 (October 2016). Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561730/State_of_Care_15-16_web.pdf. Accessed November 2017.
2. Next Steps on the NHS Five Year Forward View (March 2017). Available from: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf. Accessed October 2017.